Commission to Protect the Lives and Health of Members of the Maine National Guard

Report to the Governor and the 124th Legislature First Session

TO PROVIDE HIGHER AND SAFER STANDARDS FOR PREVENTATIVE MEDICAL PRACTICES AND HEALTH SCREENINGS ADMINISTERED TO MEMBERS OF THE MAINE NATIONAL GUARD THAN CURRENTLY EXIST AND TO ENCOURAGE THE FEDERAL MILITARY FORCES TO ADOPT THESE HIGHER STANDARDS

December 15, 2008

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Executive Summary

PUBLIC Law, Chapter 318, passed by the 123rd Maine State Legislature, created "*The Commission to Protect the Lives and Health of Members of the Maine National Guard*". From September 2007 through December 2008, this Commission held nine meetings and four public hearings, more hearings than specified by the law.

The intent of the statute is "to provide higher and safer standards for preventative medical practices and health screenings administered to members of the Maine National Guard than currently exist and to encourage the federal military forces to adopt these higher standards". It is also the intent of this law to prevent future non-combat deaths and disabilities of military personnel.

This law not only created the Commission to achieve the above intentions but also by "directing the Maine National Guard and the Maine Center for Disease Control to take such action as necessary to accomplish this purpose including coordination and cooperation between these two agencies".

The report addresses Responsibilities "A - I" as listed in the law.

Here is a summary of what the Commission has Accomplished to date, as well as, the Commission's Short Term Goals, Long Term Goals and Recommendations. The Federal Recommendations are to be included in a Joint Resolution to Congress for the consideration of the First Regular Session of the 124th Session of the Maine State Legislature.

ACCOMPLISHED: {From September 2007 to April 1, 2008}

1. Common Ground: Members come from a variety of perspectives, yet the Commission has found 'common ground', where our collective intent and commitment is to "protect the lives and health of members of the Maine National Guard".

2. 'New'- Addition To Maine Center for Disease Control Website: Initiation, current availability and on-going development of a 'one-stop-shopping' website, with Resources for Maine veterans, members of the military and their families, hosted on the Maine Center for Disease Control Internet site.

3. Army Required 'Over 40 Physical Exam': Maine National Guard Members (MENG), who are 40 years of age or over, or will turn 40 during their deployment, are now receiving cardiovascular screening including an EKG, prior to deployment. This is a higher standard than regulations require.

4. Traumatic Brain Injury Screening (TBI): Pre and post deployment screenings are being given to all deploying Maine Army National Guard (MEARNG) soldiers, through a grant with Tufts University.

5. Medical Records to Stay in Maine: Deployed soldiers' Medical Records are currently available to individuals who request them. The Army National Guard is in the process of transitioning to electronic medical records, but records are currently available in .pdf format.

ACCOMPLISHED: {From April 1, 2008 to December 15, 2008}

1. Established a Vaccination Buddies Program for the MEARNG:
   This is one of the recommendations from the military Vaccine Healthcare Center Network, which the MEARNG implemented in October 2008.

2. Established a Case Review Board for Non-Combat Deaths and Disabilities: The Commission created a Case Review Process, held a Trial Case Review and will be submitting legislation to protect privacy and confidentiality.

3. Reviewed the Collection of Serum Samples Pre and Post Deployment: Pre and post deployment serum samples have been and continue to be collected and sent to VIROMED, then forwarded to the Department of Defense Serum Repository.

4. Reviewed a Profile on Health of Maine Veterans: The compilation of Behavioral Risk Factor Surveillance Survey is a telephone survey conducted and reported by Maine CDC. Future questions will be shaped by input from the Commission.

5. Expanded Current Veterans' Database to Include Cause of Death: Cooperation has been established between the Chief Medical Examiner's Office and Veterans' Services in gathering future data.

6. Reviewed Vaccination Policies and Made Recommendations for Changes at the National Level: Commission Recommendations are to be included in a Joint Resolution to Congress for consideration during the First Regular Session of the 124th Legislature.

SHORT TERM GOALS: {December 2008 – December 2009}

1. To Implement Education Programs Utilizing Presenters Outside of Maine: To bring to Maine Col. Renata Engler, MD from the Vaccine Health Care Center at Walter Reed Hospital to present the most current information and best protocols on military vaccinations to MENG medical staff, civilian medical professionals and to carry out "Grand Rounds" at VA at Togus. When Maine hosts the New England Conference, Dr. Engler will also be one of the presenters.

2. To Expand MENG Education Programs within Maine: Information on mental health concerns, vaccination reactions and the importance of honesty and completeness in documentation of soldiers physical health issues will become an integral part of existing trainings, websites and newsletters.

3. To Create a "Return Receipt" for All Additions to Medical Files of Members of the Maine National Guard: The Maine National Guard will implement a policy to receive, store, and safeguard civilian medical documentation to ensure service members' medical records represent an accurate collective status.

LONG TERM GOALS OF THE COMMISSION:

1. To Explore Funding Through Grants For Programs such as:

    a. Quantitative Analysis of Those Suffering Gulf War Syndrome In Maine - an epidemiological assessment in a relatively small but accessible population, looking for trends in symptomatology/deaths in the absence of national data.

    b. Gulf War Veteran's Treatment Trial –a trial has already been designed and could potentially be carried out in Maine.

2. To Continue to Study the Area of Physical Screenings: The Commission shall continue to explore this priority area, to obtain consensus on what is the best approach.

3. To Track the Healthcare of all Veterans Returning to Maine: Maine Veterans' Services has developed a questionnaire and spread sheet to track identified illnesses experienced by Persian Gulf and Global War on Terror veterans. Implementation plans are being finalized. Issues to be resolved involve medical privacy (HIPAA) and federal versus state jurisdiction.

Recommendations from the Commission to Protect the Lives and Health of Members of the Maine National Guard:

Maine National Guard Command Level Recommendations:

1. That a Joint Medical Clinic be provided in Maine that is staffed on drill weekends and that specializes in pre and post deployment medical issues.

2. That immediately upon completion of a Line of Duty Investigation (LOD), with the final determination suggesting the presence of long-term or lingering military service-connected injury or disability, the Maine National Guard will strongly encourage the service member to file a concurrent Veterans Affairs claim.

State Level Recommendations:

1. That there be an advocate for returning service members and their families in the Governor's Office.

2. That legislation in the form of a Joint Resolution to the United States Congress be submitted for the consideration of the 124th Session of the Maine State Legislature that includes Federal Recommendations from the Commission to Protect the Lives and Health of the Members of the Maine National Guard.

Federal Level Recommendations:

1. That increased efforts to diagnosis and treat undiagnosed illnesses, such as those found in veterans of the 1990-1991 Gulf War and the Global War on Terror, be undertaken immediately.

2. That existing regulations regarding the medical disability process for service members be enforced and that current standards be improved.

3. That service members be granted the "benefit of the doubt" when they file a valid disability claim for service-connected injuries or illnesses: providing healthcare benefits immediately and compensation as soon as possible.

4. That the Department of Defense (DoD) adopt the electronic medical record system of the Department of Veterans Affairs (VA), and begin rapid implementation.

5. That Congress request the Institute of Medicine (IOM) to perform a review of the military smallpox program in an identical manner to its review of the civilian smallpox program, and ask the Secretary of Defense to follow the recommendations of the IOM with respect to future smallpox vaccinations. In addition, that the IOM consider whether an alternative, safer way to utilize vaccine is feasible: the ability of troops to carry smallpox vaccine with them in the field, to be used immediately post-exposure should they face an attack with smallpox. (Troops currently carry detector devices for smallpox).

6. That all anthrax vaccine safety data be made available for expert analysis, especially to decision makers and independent scientists.

That research using the Defense Medical Surveillance System (DMSS) databases specifically investigate the relationship between anthrax vaccine and chronic fatigue syndrome, fibromyalgia and other pain disorders, undiagnosed illnesses and Gulf War Syndrome.

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Introduction

Public Law, Chapter 318, *An Act To Protect the Lives and Health of Members of the Maine National Guard*, (Appendix 6) was passed by the 123d Maine State Legislature and created the **Commission to Protect the Lives and Health of Members of the Maine National Guard**.

The intent of this statute was to provide higher and safer standards for preventative medical practices and health screening administered to members of the Maine National Guard than currently exist and to encourage the federal military forces to adopt these higher standards. It is also the intent of this law to prevent future noncombat deaths and injuries of military personnel by creating the Commission and by directing the Maine National Guard and the Maine Center for Disease Control and Prevention to take such actions as necessary to accomplish these purposes including coordination and cooperation between these agencies.

Overview and History To Date

After fifteen months of gathering and processing as much information as possible on health practices and protocols in the military, focusing specifically on those administered to members of the Maine National Guard, the Commission is recommending a number of changes.

Staffers from all of Maine's Congressional Delegation have attended every meeting and have offered a valuable perspective to this work as well as those who have taken their time to come before the commission to testify at Public Hearings or have e-mailed in their written testimony.

Since much of what we found that requires change is at the federal level, a Joint Resolution to the President and Congress of the United States is being drafted to be introduced for consideration by the 124th Legislative Session, which will include the following Recommendations:

Responsibilities of the Commission

The Commission with assistance from the Department of Defense, Veterans and Emergency Management and the Maine Center for Disease Control shall address responsibilities "A thru I" as stated in the statute:

A. Review all the preventive health care treatment practices and protocols, including, but not limited to, physical and emotional screenings, vaccinations, electrocardiograms and physical examinations as they apply to members of the Maine National Guard in different age groups;

1. Army Regulation 40-501, a 127 page document titled "Medical Services: Standards of Medical Fitness" was presented to commission members by LTC Patrick J. Tangney, Maine Army National Guard State Surgeon with the opportunity to ask questions. It includes standards of medical fitness for enlistment, appointment, induction, retention and separation including retirement. It also has specific sections on medical examinations for the Guard and Reserves.

Standards of Medical Fitness, governs the medical fitness standards for the Army, to include the Army National Guard. The Regulation makes several introductory points as it relates to Medical Examinations:

- Medical fitness is an individual responsibility

- Soldiers must seek timely medical advise whenever they believe that a medical condition might affect their medical readiness

- Soldiers are responsible to report civilian medical care to their unit commanders

- Civilian health records will be placed in the reserve component soldier's military health record

In the recent past, members of the Maine National Guard were required to undergo periodic physical exams on a schedule that has been set at four or five years supplemented by submission of an Annual Medical Certificate (AMC) and a face-to-face meeting with a military doctor. This process has been replaced by an annual Periodic Health Assessment (PHA), which consists of three parts:

- A self-reported health status to include a statement of health completed by the soldier

- A review of the soldiers height and weight, current medical conditions and deployment related health problems, to include screening for traumatic brain injury exposure, allergies, medications, required immunizations, update of medical readiness lab tests, audiology, and optometry examination results

- A review of Parts 1 and 2 by a physician, nurse practitioner or physicians assistant

It should be noted that the Cardiovascular Screening Program (CVSP), consisting in part of fasting blood sugar, fasting lipid profile, EKG and smoking history, has only been required of soldiers age 40 and older. During the period of four and/or five year periodic medical examinations, it was possible for soldiers over 40 to be deployed without the CVSP if they had turned 40 but were not due a periodic physical until after they returned from deployment. While the PHA process will significantly limit the possibility of this happening since they are conducted annually, the Maine National Guard has agreed that cardiovascular screenings (CVSP) will be carried out on all soldiers prior to deployment who are 40 or will turn 40 during their deployment cycle.

2. EKGs

Findings:

EKGs have sometimes been performed as late as five years following the 40th birthday, in accord with the "window of 5 years from the time of the last complete physical". The Army requires a 40 year-old physical, which includes cardiovascular screening and an EKG. Age 40 is the first time in a soldier's Army career that an EKG is required in accord with military regulations.

The Maine Army National Guard has changed its policy and now gives the required 40 year physical, including cardiovascular screening and an EKG, to all who have turned 40 or will reach

40 during deployment to Iraq and Afghanistan. This is an example of Maine having enacted a higher standard than the federal regulation.

Accomplishments:

a) EKGs are being performed within 12 months of the 40th birthday of National Guard members.

b) For service members who will turn 40 during deployments outside the United States, EKGs will be performed prior to those military deployments.

Recommendations:

a) EKGs will additionally be performed every five years after age 40, and within 12 months of the 45th, 50th, 55th and 60th birthdays.

b) All EKGs will be interpreted by a licensed medical practitioner who has been credentialed in EKG interpretation by a Maine healthcare facility and reviewed by a National Guard physician in the context of the rest of the service members' physical examinations.

3. Pre & Post Deployment Serum Collection

The 2005 National Defense Authorization Act established standards for the collection of pre & post-deployment blood specimens. **Department of Defense Requirements:** Assistant Secretary of Defense for Health Affairs Policy Memo dated 14 March 2006 further defines the requirement to collect pre-deployment serum specimens for medical examinations within one year of deployment. Post deployment serum specimens must be collected no later than 30 days after arrival at the demobilization site, home station, or in-patient treatment facility. The National Guard Nationwide established contract (VIROMED) used to test for HIV is also used for the pre and post deployment serum specimen collection. **National Guard Testing and Collection:** Four VIROMED barcode labels are required for each individual sample; one for the serum separator tube, one on a Standard Form 600, one on the white copy of the US ARMY HIV ANTIBODY REQUEST FORM and one on the yellow carbon form with appropriate administrative information. Serum specimens are shipped via FEDEX to VIROMED Labs in Minnetonka, Minnesota for testing. Service members' pre and post deployment serum samples are then forwarded to the Department of Defense Serum Repository (DoDSR) maintained by the Armed Forces Health Surveillance Center (AFHSC), formerly Army Medical Surveillance Activity (AMSA). The repository is located in Silver Spring, Maryland. The availability of serial serologic specimens as well as relevant demographic, occupational, and medical information within the databases at AFHSC enables the DoDSR to make significant contributions to clinical and seroepidemiologic investigations.

For more information, Armed Forces Health Surveillance Center website;
http://afhsc.army.mil/

4. Self-reported Mental Health Status and Needs of Iraq War Veterans in the Maine Army National Guard

The war in Iraq has raised important concerns regarding mental health problems suffered by Iraq veterans and the treatment resources that will be required to address the needs of these veterans. Almost 90% of the Maine Army National Guard has been deployed to Iraq, and anecdotal reports have suggested that some Iraq veterans are experiencing significant problems in relationships with family and friends, problems at work, and difficulty in day-to-day functioning.

The research project was developed and conducted by Dr. Elizabeth Wheeler, in collaboration with Major General John W. Libby and his chief medical officer, Colonel Kimberly Boothby-Ballantyne. The Survey Research Center at the Muskie School of Public Service at the University of Southern Maine provided consultation on research design and survey development, and provided data entry and analysis. The project was funded by the Community Counseling Center in Portland, Maine, which contracted Dr. Wheeler to investigate the needs of returning veterans.

In 2006, surveys were completed anonymously by all National Guard members in Maine unless they were deployed or engaged in other Guard-related activities. Surveys were administered at weekend drills in Augusta (two units), Bangor (five units), Belfast, Caribou, Gardiner, Houlton, Lewiston, Norway, Portland, Presque Isle, Sanford, Skowhegan, Waterville, and Westbrook. A total of 532 Guard members were surveyed, of which 292 were Iraq veterans. Most of the Iraq veterans had returned a year before they completed the survey.

Other sites of deployment included Hurricane Katrina, the Persian Gulf, Bosnia, Afghanistan, Guantanamo Bay, Viet Nam, and Kosovo. There were not sufficient numbers of veterans from any of these other sites to analyze their data separately or draw conclusions about their mental health issues. When analyzed as a group, National Guard members who had been deployed to sites other than Iraq generally reported less severe levels of disturbance than Iraq veterans but greater levels of combat exposure, life stress, posttraumatic stress symptoms and problems with alcohol than Guard members who had not been deployed at all. The results for Iraq veterans are reported below.

Guard members' experiences in the war zone

Over three-quarters of Iraq veterans reported that they had been exposed to life, threatening experiences such as being shot at, going on combat patrol, or other situations in which they were in danger of being injured or killed. Similar numbers also had seen dead bodies and/or had known someone who was killed or seriously injured. The severity of these traumatic experiences is highly significant, and is similar to the reported severity of combat trauma among members of the Army deployed to Iraq.

Posttraumatic stress reactions

"Hyperarousal" symptoms were reported by well over one third of Iraq veterans and were the most frequently reported symptoms. These include feeling jumpy or easily startled, feeling keyed up and irritable, having angry outbursts, having difficulty with sleep and concentration, and generally having difficulty relaxing and "letting their guard down". "Re-experiencing" symptoms, reported by approximately one quarter of Iraq veterans, include experiences such as flashbacks (when upsetting images of the war-zone flash into their mind, making it difficult to think or concentrate), nightmares, and feeling very upset and having physical reactions (such as heart pounding, trouble breathing) when something reminds them of a war zone experience. Feeling emotionally numb was reported by roughly one third of Iraq veterans. This includes feeling

unable to have loving feelings for those close to them, feeling distant and cut off from other people, and losing interest in activities they used to enjoy.

A diagnosis of PTSD requires that all three of the above types of reactions be strongly present. Our findings indicate that at least 13% of Iraq veterans in Maine would qualify for a diagnosis of PTSD. This is similar to published reports of PTSD for members of the Army and Marines who served in Iraq.

One quarter of Iraq veterans also reported that they drink too much alcohol, which is a common way many try to avoid upsetting traumatic stress reactions. Unfortunately, alcohol abuse adds to the problems caused by PTSD by interfering with relationships, job performance, and other key areas of functioning.

Depression

Significant symptoms of depression were reported by over one in four Iraq veterans. Symptoms included feeling tired and having little energy, not being interested in pleasurable activities, poor concentration, and changes in appetite and sleep patterns. Depression sometimes causes people to think about hurting or killing themselves, and one in ten Iraq veterans acknowledged such thoughts. (It should be noted that among Guard members who had not been deployed, one in fourteen reported similar thoughts, which is only slightly higher than the rate for the general population.)

Effects on relationships, work, and personal life

Iraq veterans face a variety of challenges in readjusting to life with their families and communities. Our research indicates that a year after returning from Iraq, veterans are having significant problems in relationships with partners and children. Many veterans reported that they experienced significant stress in these primary relationships. In addition to having more interpersonal conflict, many Iraq veterans indicated that they felt disconnected or detached from loved ones and civilian friends. They frequently reported not having fun in life and not being able to relax. Combat stress reactions, such as problems with anger or concentration, having trouble sleeping, or problems relating to people, can also make returning to work very difficult, and large numbers of veterans reported significant stress at work. Significant financial stress was also frequently reported, as were physical health problems.

Interest in mental health treatment

Very few Iraq veterans had sought help for readjustment problems, although roughly one third of veterans said they were interested in receiving help. Iraq veterans said the kinds of services they were most interested in were support groups with other veterans, individual counseling, education regarding war zone stress and the readjustment process, anger management, and couples' counseling. Iraq veterans also said they thought family members would be interested in services such as couples' counseling, support groups for family members, education regarding readjustment issues, and individual counseling.

Conclusions

This study provides the first systematic assessment of members of the Maine National Guard who were deployed to the Iraq war. Our findings indicate that large numbers of Iraq veterans report

mental health problems as well as significant stress in relationships with family and friends and problems at work Members of the Guard deployed to other sites also report significant but less severe readjustment issues, consistent with their lower level of combat exposure. Our findings establish the need to address the readjustment concerns of Iraq veterans.

Fortunately, effective, evidence-based treatments exist and early treatment can prevent worse problems from developing. Needed services include specialized educational support and therapy groups for veterans and their partners, individual and couples therapy, as well as specialized evidence-based trauma treatments for individuals experiencing significant posttraumatic stress reactions. To meet the needs of our Maine National Guard citizen soldiers as they return to their families, communities and workplaces, it is extremely important to have a strong network of services available to them in their communities.

B. Review the vaccinations and other medications currently provided to members of the Maine National Guard, particularly those that produce allergic reactions and dangerous side effects, and compare the vaccinations and medications with those recommended by the National Institutes of Health, the United States Food and Drug Administration and other sources of standards of medical care;

1. Army Regulation 40-562, a 31 page document, "Medical Services: Immunizations and Chemoprophylaxis" contains the program elements and specific immunization requirements that the Maine National Guard must follow.

The number of vaccinations that are given at a time and the number given overall during a military career even to Guard and Reserves is an area of major concern. Two specific vaccines that have been discussed in greater depth because of related allergic or adverse reaction problems are the Smallpox and Anthrax vaccines.

2. Problems with Military Vaccines presented by Dr. Meryl Nass reads as follows:

Although biological warfare is considered a military threat, achieving mass casualties is extremely difficult. Historically, the target has been civilians, not troops. Nonetheless, the Defense Department has undertaken to vaccinate all deploying soldiers to Central Command with anthrax and smallpox vaccines: approximately 1.8 million soldiers have received each in the past ten years.

In retrospect, the current administration used the threat of chemical and biological warfare to buttress a preemptive strike on Iraq in 2003. Initiating smallpox vaccinations for soldiers and civilians may have had more to do with public relations than public health. The civilian program stopped after 40,000 inoculations, due to cardiac complications.

Despite this, the mandatory military smallpox vaccination program has never slowed down. According to the CDC Advisory Committee for Immunization Practices, such vaccination programs require a risk-benefit analysis, which was never performed. The Institute of Medicine's analysis of the smallpox program noted, "The combination of known vaccine-related problems and an immeasurable disease threat was deeply problematic."

The smallpox vaccine caused myocarditis in one of every 145 people who received it in a clinical trial, leading to a black box warning in the label. However, the warning fell on deaf ears, since the vaccine remained a requirement for deployment.
Recently, a newer smallpox vaccine, derived from the old vaccine, was licensed. The government announced that stocks of the old vaccine would be destroyed, and the new vaccine would be given to soldiers. But is there really a difference? The new vaccine is said to cause myocarditis in one in 175 recipients.

The anthrax vaccine story is similar: the General Accounting Office reported to Congress in both 1999 and 2006 that the long-term safety of the vaccine is unknown. Crucial data and research remain buried.

Although civilians injured by smallpox vaccine can seek compensation from a government fund, soldiers are barred by the Feres Doctrine from compensation, and their only recourse in the event of illness is the healthcare system of the military and Veterans Administration. Unfortunately, vaccine-induced illnesses generally respond poorly to treatment.

In the absence of both demonstrable threat and effectiveness against biological weapons, these pork barrel vaccine programs exact much too high a price from our service-members and our treasury. It is time to end the politicization of military public health.

One recommendation to improve vaccine safeguards from the Vaccine Healthcare Center is to initiate "A Vaccination Buddies Program". The MEARNG State Surgeon has committed to initiate this program into the MEARNG medical protocols.

3. The MEARNG immunization program:

The Maine Army National Guard (MEARNG) administers immunizations, which are directed as part of "basic series" as directed in Army Regulation 40-501, *Standards of Medical Fitness*. Soldiers who have been identified by their commands for deployment receive immunizations as directed by the Department of the Army Personnel Policy Guidance, PPG prior to deployment to theatre. The list below describes what the Soldier is expected to receive from the MEARNG prior to leaving for Mobilization Station (Maine).

Basic Series immunizations administered by the MEARNG:

1. Hepatitis A (2 doses per dosage schedule)
2. Hepatitis B (2 doses to continue 3 dose series started at Basic Training per dosing schedule)
3. or Twinrix (3 doses) instead of separate Hep A and Hep B series
4. Tetanus/Diphtheria (booster every 10 years) and Pertussis (one time booster)
5. Influenza (annual)

Currently, PPG directed immunizations administered by the MEARNG prior to leaving Maine for mobilization to Iraq and Afghanistan:

Anthrax (dose 1, 2 and 3 or continue dosage schedule or annual booster)

PPG directed test administered by the MEARNG after returning from deployment:

Tuberculosis Skin Test (one test 3-6 months after returning to Maine)

Current MEARNG immunization procedures:

1. No Soldier will receive more than 2 immunizations in one day.
2. No Soldier will receive more than 1 live virus in one day.
3. No Soldier will receive any live virus vaccine within 30 days of expected mobilization station arrival date.
4. Each Soldier completes and signs a contraindication questionnaire every time prior to receiving immunization. The immunization team reviews this questionnaire and determines whether the Soldier should be receiving a particular or any immunizations.
5. The immunization team reviews the Soldier's physical medical record, any documents brought in by civilian providers and the individual's electronic MEDPROS record for current immunization history and any shot exceptions to determine which immunizations the Soldier is eligible to receive.
6. Each Soldier is notified which immunization he/she will be receiving at the time of administration of the shot.
7. As of October 2008, each Soldier is handed an information sheet or brochure which describes the immunization he/she received. The information material is prepared by the Center for Disease Control and includes what the immunization is and why the Soldier would be receiving it, potential side effects and who to contact if the Soldier has any questions.
8. Prior to being given Anthrax immunization for the first time, each Soldier receives an Anthrax immunization brief published by the Department of Defense regarding the Anthrax immunization.
9. Females are given a pregnancy test and results received every time prior to receiving any immunization, except influenza.
10. As of October 2008, each Soldier will have an identified "immunization buddy". Each buddy pair is identified on a roster supplied by the unit receiving immunizations. The immunization buddy pair is two Soldiers that are expected to be in regular contact with each other over the remaining training day. Each immunization buddy team is aware that the other received an immunization and is to be aware of general condition of his/her buddy. The immunization buddy can confirm whether or not their buddy received any immunizations in the event their buddy is non-responsive.

4. Smallpox Vaccine

Background:

Smallpox vaccine is given to all deploying service members in a program begun in December 2002. No evidence of a high or increased risk of smallpox for service members has been presented since the program started. The vaccine is associated with a high risk of cardiac complications, especially myopericarditis. The old, stored New York State Department of Health vaccine was used until early 2008, when the military switched to newly licensed ACAM 2000 vaccine. Both vaccines have been associated with the increased risk of cardiac complications.

The ACAM 2000 package insert (a.k.a. vaccine label) contains a "black box" warning indicating that one in 175 recipients can be expected to develop the myopercarditis complication. The warning lists a number of other potential complications, including encephalitis. The insert indicates the vaccine is to be used for "persons deemed to be at high risk for smallpox infection." Relevant pages of the package insert are attached to this report.

Civilian Smallpox Vaccination Program

The Institute of Medicine (IOM) of the National Academy of Science was charged by CDC with providing advice on the 2003 civilian smallpox program's implementation and evaluation. The IOM committee wrote 6 "letter" reports, and issued its final, summary report in 2005.[1] The report made many interesting observations, including the following:

> *"Vaccination is an effective public health tool in cases where the known risks of the vaccine are weighed against the known benefits of the vaccine and the risk of disease."*[2]
>
> *"Military smallpox vaccination from 1984 was limited to recruits entering basic training, and it was finally discontinued in 1990."*[3]
>
> *"The combination of known vaccine-related problems and unmeasurable disease threat was deeply problematic."*[4]
>
> *"The committee also emphasized the program's voluntary nature, and the need for a focus on safety, requiring active monitoring of side effects related to vaccination."*[5]
>
> *"Also, the final phase of the program would offer a potentially harmful vaccine in the context of an unknown risk, creating a philosophic conflict with health care and public health workers' injunction to "do no harm.'"* [6]
>
> *"… at times, information about adverse events in the military program was not communicated to the public or to the public health community in a timely fashion."*[7]
>
> *"It was also more difficult to identify adverse events specifically caused by the smallpox vaccine in the military population, because members of the military often received multiple concurrent vaccinations."*[8]
>
> *The committee has previously expressed its hope that the Department of Defense Serum Repository and the Millennium Cohort Study will serve as resources for CDC as it follows up vaccines and learns about the long-term sequellae of serious adverse events."*[9] *"The committee is not aware of whether CDC has conducted a comprehensive assessment of the safety data system functioning, the completeness of the data gathered, and their relevance to the continuation of vaccination efforts."*[10]

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[1] Committee on Smallpox Vaccination Program Implementation, Institute of Medicine. The smallpox vaccination program' public health in an age of terrorism. The National Academies Press, Washington, D.C. 2005.
[2] Ibid. page 16.
[3] Ibid. page 22.
[4] Ibid. page 26.
[5] Ibid. page 44.
[6] Ibid. page 49.
[7] Ibid. page 60.
[8] Ibid. page 60.
[9] Ibid. page 60.

"…it was never made clear to the public health and health care communities why smallpox was selected as a primary target for biopreparedness, how pre-event smallpox vaccination was identified as a core strategy, and why vaccination was urgent."[11]

The civilian program ceased due to serious reported side effects (including deaths) and lack of information confirming the program's urgent need. Despite exhaustive searching, no weapons of mass destruction could be found in Iraq.

Military Smallpox Vaccination Program

However, while the civilian vaccination program collapsed in mid 2003, the military vaccination program neither slowed down nor ceased. Over 1,600,000 soldiers have received smallpox vaccinations since December 2002.[12] Yet the military's smallpox vaccine website claims that only 140 persons of the initial 1,200,000 vaccinated developed myopericarditis:[13] a rate only one-fiftieth as high as listed in the package insert. As noted in the IOM report, by giving multiple vaccinations at the same time as smallpox vaccine, the side effects associated with smallpox vaccine could not be precisely identified.

Furthermore, soldiers deployed soon after being vaccinated, and were in a war zone at the time they would most likely show side effects. Medical care was limited in the field, and it is likely most symptoms were ignored in that setting. Although most affected soldiers probably made a complete recovery, the treatment of acute myopericarditis requires rest. It is unlikely many affected soldiers in Iraq and Afghanistan were able to receive this treatment, which may have worsened the long-term outlook for some. Given 1,600,000 military smallpox vaccinations and a rate of 1 in 175 cases of myopericarditis, over 9,000 soldiers can be expected to have developed this side effect; but under 200 have been diagnosed and treated.

According to a study[14] of smallpox vaccine-associated myopericarditis conducted by military physicians:

Treatment is with non-steroidal anti-inflammatory agents, four to six weeks of limited exertion, and conventional heart failure treatment as necessary. Immune suppressant therapy with steroids may be uniquely beneficial in myopericarditis related to smallpox vaccination, compared with other types of myopericarditis. If a widespread vaccination program is undertaken in the future, many more cases of post-vaccinial myopericarditis could be seen. Practicing physicians should be aware that smallpox vaccine-associated myopericarditis is a real entity, and symptoms after vaccination should be appropriately evaluated, treated if necessary, and reported to the Vaccine Adverse Events Reporting System.

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[10] Ibid. page 62.
[11] Ibid. page 82.
[12] http://www.smallpox.army.mil/
[13] http://www.smallpox.army.mil/event/SPSafetySum.asp
[14] Cassimatis D, Atwood J, Engler R et al. Smallpox vaccination and myopericarditis: a clinical review. Journal of the American College of Cardiology 2004. Volume 43, Issue 9, Pages 1503 - 1510

Our commission was concerned about this problem, and considered a change in vaccination practice in the Maine Army National Guard, vaccinating soldiers several months prior to deploying. Soldiers could then be observed for potential side effects and treated accordingly. However, such a change has not been possible so far due to the risk of spreading the virus to family members. However, spread of vaccinia virus to family members of soldiers has occurred at a very low rate since the program started.

Findings:

a) Soldiers continue to receive smallpox vaccine, although the vaccine was considered too dangerous for civilians.

b) Evidence for an increased risk of smallpox for soldiers has not been presented and may not exist. Both the Institute of Medicine (IOM) and the smallpox vaccine's package insert indicate the vaccine should only be used in a situation of increased risk of smallpox bioterrorism, because the natural disease has been eradicated.

c) Public health practice balances risk of disease with risk of infection and benefit of the treatment, in this case smallpox vaccine. This calculation has not yet been made for the smallpox vaccination program, which has now been running for 6 years although it is considered essential to good public health practice.

d) Only limited medical follow-up of soldiers who received smallpox vaccine has been performed, leading to reported rates of vaccine complications in the military that are far below those found by CDC and during clinical trials of the vaccine. Reliable information on the vaccine's long-term adverse events are lacking, as is information on the rates of complications other than myopericarditis.

e) The rate of myopericarditis in vaccinated individuals during clinical trials was 5.7 per 10,000 vaccinated, or 1 in 175 vaccinations (95% confidence interval 1.9-13.3 per 10,000).[15]

f) A suggestion to enhance the diagnosis and treatment of the vaccine's subacute side effects (such as myopericarditis) by vaccinating earlier, which would allow more time for medical surveillance to take place before soldiers deployed from Maine, could not be implemented.

g) Smallpox vaccine has been effective at preventing smallpox disease even when administered up to 4 days after exposure to the virus.

Recommendations:

a) That Congress request IOM to perform a review of the military smallpox program in an identical manner to its review of the civilian smallpox program, and ask the Secretary of Defense to follow the recommendations of the IOM committee with respect to future smallpox vaccinations.

[15] Package insert, page 1: ACAM 2000. www.fda.gov/CBER/label/acam2000LB.pdf

b) That IOM consider whether an alternative, safer way to utilize vaccine is feasible: for example, the ability of troops to carry smallpox vaccine with them in the field, to be used immediately post-exposure should they face an attack with smallpox. Troops currently carry detector devices for smallpox.

5. Anthrax Vaccine

Background:

Anthrax vaccine is given to all deploying service members in a program that began in March 1998. No evidence of high or increased risk of anthrax for service members has been presented since the program started. The program has been halted twice: once in 2000 because of a vaccine shortage (FDA quarantined five million doses of vaccine that were outside the manufacturers' specifications due to lack of sterility, lack of potency and/or degradation of the stoppers on vaccine vials) and a second time in 2004 due to a court order that the vaccine had never completed required procedures for licensure.

The manufacturing facility was rebuilt at taxpayer expense in 1998-9 due to manufacturing flaws. FDA only reapproved it for use in January 2002, after the anthrax letter attacks. After FDA completed specified licensing procedures in response to the court order, it relicensed the vaccine and the vaccination program began again in 2006. Over 2 million service members have received over 8 million doses of anthrax vaccine since the program started.[16]

Due to many reports of vaccine-related illnesses, the military was directed by Congress to establish Vaccine Healthcare Centers (VHCs) of which there are four in the US. The VHCs have performed complete evaluations on over 2,000 soldiers reporting anthrax vaccine-related illnesses. The clinic director of the Walter Reed VHC, who has worked there for the past 8 years, stated that the complex of symptoms that "translates to chronic fatigue syndrome" has been seen very often after anthrax vaccine, and is like Gulf War Syndrome.[17]

An IOM report on anthrax vaccine[18] was completed in 2002, 5 months after the anthrax letter attacks. Although the report stated the vaccine was sufficiently safe and effective, "the report committee made it clear that the vaccine should be given only to those at high risk for exposure."[19]

The vaccine has been controversial since beginning widespread use in 1998. One reason the controversy has persisted is the lack of reliable data on the long-term adverse reactions associated

[16] http://www.anthrax.osd.mil/

[17] Copy of email from Jeannette Williams dated October 15, 2008 was supplied to the commission at its October 23, 2008 meeting.

[18] Institute of Medicine Committee to Assess the Safety Safety and Efficacy of Anthrax Vaccine. The Anthrax Vaccine: Is It Safe? Does It Work? National Academies Press, Washington, D.C. March 2002

[19] Vastag B. Despite finding anthrax vaccine useful, IOM recommends seeking a better one. JAMA 2002: March 27; 287 (12) 1516-7.

with anthrax vaccine. Every expert group asked to review the anthrax program over the past ten years has recommended a study of long-term effects.[20]

The vaccine's FDA-approved package insert notes that military studies of vaccine safety were confounded by a number of methodological problems:

> *"… adverse events following anthrax vaccination have been assessed in survey studies conducted by the Department of Defense in the context of their anthrax vaccination program. These survey studies are subject to several methodological limitations, e.g., sample size, the limited ability to detect adverse events, observational bias, loss to follow-up, exemption of vaccine recipients with previous adverse events and the absence of unvaccinated control groups."*[21]

The package insert also lists the CDC definition of Gulf War Syndrome as a reported adverse reaction to anthrax vaccine.

Two studies have been conducted to determine long-term side effects. The first study, conducted at Tripler Army Medical Center from 1998 to 2000, was intended to study 603 medical personnel over 18 months while they received the six-dose vaccine series. However, the final report [22] only presented data on the first 4 inoculations, failed to explain why a significantly increased number of women reported fair or poor health at the study's conclusion, and lost most subjects to follow-up before the initial vaccine series was completed. Three of the subjects (0.5%) developed serious neurologic disorders early in the study.

A second, Congressionally-mandated CDC study of long-term safety began in 2002, enrolled 1564 subjects at five centers, and followed them over 43 months. A final analysis was due in April 2007, according to a CDC presentation about the trial.[23]

However, only an interim paper has been published on this trial so far, discussing the first seven months of follow-up.[24] Although 229 serious adverse events, including seven deaths in subjects, were reported to the Vaccine Adverse Event Reporting System during the full duration of the trial, the published paper only tells us what nine of them were.

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[20] http://merylnass.googlepages.com/FINALEveryExpertctteminusPOG.doc
[21] www.fda.gov/OHRMS/DOCKETS/98fr/05n-0040-bkg0001.pdf
[22] Glenn M Wasserman, John D Grabenstein, Phillip R Pittman et al. Analysis of adverse events after anthrax immunization in US Army medical personnel. J Occup Environ Med. 2003 Mar ;45 (3):222-33.
[23] The CDC presentation slide of the study's timeline has been uploaded here: http://merylnass.googlepages.com/CDChumantrialtimeline-slide.pdf
[24] Nina Marano, DVM; Brian D. Plikaytis, MSc; Stacey W. Martin, MSc. Effects of a Reduced Dose Schedule and Intramuscular Administration of Anthrax Vaccine Adsorbed on Immunogenicity and Safety at 7 Months: A Randomized Trial. JAMA 2008; 300 (13): 1532-1543.

Data from the military Defense Medical Surveillance System (DMSS) have not been used appropriately to study anthrax vaccine safety, despite recommendations from the 2002[25] and 2003[26] IOM committees on anthrax vaccine, which note that this database contains the most important information on the long-term safety of anthrax vaccine.

The 2003 IOM committee made the following finding and recommendations, but there is no public evidence that the recommendations have been carried out:

> *Finding: DMSS is a uniquely valuable resource for testing hypotheses regarding medically significant health effects of exposure to AVA or other vaccines, especially those that might arise several months after vaccination but within the period of active duty.*[27]
>
> *Recommendation: Analysis of DMSS data should be the primary approach for investigation of possible AVA*[28]*-related health effects of medical significance that occur within the typical period of active duty following vaccination.*[29]
> *Recommendation: A committee of nongovernmental experts should be established to periodically advise CDC on plans and priorities for the analyses of data from DMSS and other sources to test hypotheses regarding health effects related to AVA*[30].
>
> *Recommendation: Adequate resources (substantially more than can currently be identified from the CDC–DoD Memorandum of Understanding) should be made available to support the use of DMSS data for testing hypotheses regarding health effects related to AVA(Anthrax Vaccine Adsorbed) or other vaccine exposures.*[31]

A 2007 GAO report[32] acknowledged that,

> *"Officials from the VHC Network and CDC estimate that between 1 and 2 percent of immunized individuals may experience severe adverse events, which could result in disability or death."*

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[25] Institute of Medicine Committee to Assess the Safety Safety and Efficacy of Anthrax Vaccine. The Anthrax Vaccine: Is It Safe? Does It Work? National Academies Press, Washington, D.C. March 2002

[26] http://www.nap.edu/catalog.php?record_id=10527#toc

[27] Institute of Medicine committee to review the CDC anthrax vaccine safety and efficacy research program. An assessment of the CDC anthrax vaccine safety and efficacy research program. National Academies Press. Washington, D.C. 2003. Pages 76-77. http://books.nap.edu/openbook.php?record_id=10527&page=76

[28] The licensed anthrax vaccine was named AVA (anthrax vaccine adsorbed) until 2002; it is now named Biothrax.

[29] http://books.nap.edu/openbook.php?record_id=10527&page=77

[30] http://books.nap.edu/openbook.php?record_id=10527&page=78

[31] http://books.nap.edu/openbook.php?record_id=10527&page=78

[32] GAO. Military Health: DOD's Vaccine Healthcare Centers Network. GAO-07-787R. June 29, 2007. page 4. http://www.gao.gov/cgi-bin/getrpt?GAO-07-787R

Assistant Secretary of Defense for Health Affairs Dr. S. Ward Casscells concurred with the report's findings and results in a letter included in the report.

On October 1, 2008 DHHS Secretary Leavitt issued a declaration under the 2005 Public Readiness and Emergency Preparedness Act[33] [34] [35] invoking an anthrax emergency, which will shield the manufacturer and government officials from liability lawsuits resulting from anthrax vaccine injuries, and injuries resulting from use of specified anthrax, smallpox, botulinum toxin and radiation sickness countermeasures, including smallpox vaccine. No evidence of an anthrax emergency exists, but evidence is not needed to invoke an emergency declaration and liability shield.[36]

On October 23, 2008, the CDC's Advisory Committee on Immunization Practices voted to overturn their 2000 and 2002 recommendation against using anthrax vaccine in civilians who were not exposed to anthrax spores on more than one occasion, and approved use of the vaccine in civilian first responders.[37]

Findings:

a) Soldiers continue to receive mandatory anthrax vaccinations, although the vaccine's safety has never been demonstrated, and there are good reasons to suspect the vaccine causes severe side effects.

b) No reliable data on the long-term effects of anthrax vaccine exist in the public domain. Data that could help resolve the lack of long-term safety information have been sequestered, especially the Defense Medical Surveillance System (DMSS) database, despite a Congressional directive to CDC to study long-term effects.

c) The vaccine package insert, the Vaccine Healthcare Centers and the CDC (reporting to GAO in 2007) all suggest that severe adverse reactions occur following anthrax vaccinations, and may lead to disability or death. A relatively common sequella is the symptom complex associated with chronic fatigue syndrome/ Gulf War Syndrome.

d) No increased risk of anthrax in soldiers has been demonstrated.

e) No risk/benefit calculation has been made for military anthrax vaccinations to conform to public health standards.

f) Vaccine efficacy has never been demonstrated in humans for this vaccine (despite the fact that FDA regulations require this evidence for licensure), and CDC has been conducting a primate trial to generate indirect evidence of efficacy.

[33] http://edocket.access.gpo.gov/2008/E8-23547.htm
[34] http://www.dhs.gov/xlibrary/assets/ofsec_signed_determination092308.pdf
[35] http://www.usembassy.at/en/download/pdf/medical_biodefense.pdf
[36] http://www.dhs.gov/xlibrary/assets/ofsec_signed_determination092308.pdf
[37] http://www.cidrap.umn.edu/cidrap/content/bt/anthrax/news/oct2308anthrax-jw.html

g) After the anthrax letter attacks, 100 percent of anthrax-exposed individuals who took antibiotics were prevented from developing anthrax. During the Gulf War, inadequate supplies of anthrax vaccine led the military to supply blister packs of ciprofloxacin to deployed soldiers as a preventive measure for anthrax. Soldiers on deployment carry anthrax detection equipment.

h) Civilian first responders are poised to begin anthrax vaccinations while the vaccine's manufacturer has just been shielded from all liability for injuries that may occur as a result.

i) Anthrax and smallpox emergencies have been declared under PREPA despite lack of evidence of increased risk for either condition.

Recommendations:

a) That Congress request that the Defense Department provide its evidence of increased anthrax risk to soldiers

b) That mandatory anthrax vaccinations cease if convincing evidence of increased risk is not provided

c) That soldiers be given the choice of receiving either anthrax vaccinations or an antibiotic blister package, which could be started at the first sign of anthrax attack and is expected to have high efficacy.

d) That Congress require that the DMSS database as well as CDC, VA and other vaccine safety databases obtained at taxpayer expense be anonymized and shared with independent researchers in a timely fashion to derive conclusive information on the adverse effects of anthrax vaccine.

e) That research using these databases specifically investigate the relationship between anthrax vaccine and chronic fatigue syndrome, fibromyalgia and other pain disorders, undiagnosed illnesses and Gulf War Syndrome.

C. Propose recommendations and seek approval from the Armed Forces of the United States for safer health care practices and protocols to be administered to members of the Maine National Guard;

After fifteen months of gathering and processing as much information as possible on health practices and protocols in the military, focusing specifically on those administered to members of the Maine National Guard, the Commission is recommending a number of changes.

Staffers from all of Maine's Congressional Delegation have attended every meeting and have offered a valuable perspective to this work as well as those who have taken their time to come before the commission to testify at Public Hearings or have e-mailed in their written testimony.

Since much of what we found requiring change is at the federal level, a Joint Resolution to the President and Congress of the United States is being drafted to be introduced for consideration by the 124th Legislative Session, which will include the following Recommendations:

Recommendations from the Commission to Protect the Lives and Health of Members of the Maine National Guard:

Federal Level:

1. That diagnosis and treatment for undiagnosed illnesses, such as those found in veterans of the 1990-1991 Gulf War and the Global War on Terror, be resolved in a timely manner.

2. That existing regulations to improve the medical disability process for service members be enforced and that current standards be improved. That Congress Ensure the DES Pilot Process is expanded as quickly as possible.

3. That service members be granted the "benefit of the doubt" when they file a valid disability claim for service-connected injuries or illnesses: providing healthcare benefits immediately and compensation as soon as possible.

4. That the DoD adopt the VA's electronic medical record system immediately.

5. That Congress request the Institute of Medicine (IOM) to perform a review of the military smallpox program in an identical manner to its review of the civilian smallpox program, and ask the Secretary of Defense to follow the recommendations of the IOM with respect to future smallpox vaccinations. In addition, that the IOM consider whether an alternative, safer way to utilize vaccine is feasible: the ability of troops to carry smallpox vaccine with them in the field, to be used immediately post-exposure should they face an attack with smallpox. Troops currently carry detector devices for smallpox.

6. That all anthrax vaccine safety data be made available for expert analysis, especially to decision makers and independent scientists.

7. That research using the Defense Medical Surveillance System (DMSS) databases specifically investigate the relationship between anthrax vaccine and chronic fatigue syndrome, fibromyalgia and other pain disorders, undiagnosed illnesses and Gulf War Syndrome.

State Level:

1. That there be an advocate for returning service members in the Governor's Office.

2. That legislation in the form of a Joint Resolution to the United States Congress be submitted for consideration by the 124th Session of the Maine State Legislature that includes the Recommendations of the Commission to Protect the Lives and Health of the Members of the Maine National Guard.

Maine National Guard Command Level:

1. That a Joint Medical Clinic be provided in Maine that is staffed on drill weekends and that specializes in pre and post deployment issues.

2. That immediately upon completion of a Line of Duty Investigation (LOD), with the final determination suggesting the presence of long-term or lingering military service-connected injury or disability, the Maine National Guard will strongly encourage the service member to file a concurrent Veterans Affairs claim.

Significant Report for Gulf War Illness Issued November 17, 2008:

The report "Gulf War Illness and the Health of Gulf War Veterans: Scientific Findings and Recommendations" by the VA Research Advisory Committee on Gulf War Veterans' Illnesses (a.k.a. RAC) was issued on November 17, 2008. The report confirms that Gulf War illness is a true medical disorder, affecting 25% of veterans of the first Gulf War, and emphasizes the need for additional research into exposures and effective treatments.

The report underscores our need to learn whether significant numbers of Iraq and Afghanistan veterans are developing similar illnesses.

It is important in many ways, since it is the most comprehensive report on GWS, with over 1800 citations. It accurately describes the illnesses and the incidence of cases (at least 25% of those who served in the Gulf theater) and the fact that most remain ill. It emphasizes the need to find useful treatments for these veterans.

Comments On The Gulf War Illness Report:

However, the report has internal inconsistencies that are troubling. The biggest problem is the report's simplistic executive summary. This summary differs from the conclusions in the body of the report for anthrax vaccine and depleted uranium, in particular. The body of the report evaluates the available data [1]—which in both cases is highly suggestive of a deleterious effect on veterans—and points out the important gaps that remain in our understanding of these two exposures.

However, the executive summary indicates they have been "ruled out" as causing the illnesses.

The report may have been too ambitious. It seeks a simple and clear-cut resolution to the problem of Gulf War illnesses' etiology, and asserts one has been found. But there may not be a simple answer. Yes, a chemical cause exists. However, this answer is not really new. The single and (especially) combined effects of pesticides, PB, and sarin have been studied by many researchers, and are known to have the potential to cause GWS symptoms. For instance, their neurobehavioral effects were discussed in my Senate testimony of September 2007, in which they were noted to be part of the problem:
http://docs.google.com/Doc?id=dc3wqmd7_286w6z99

However, very few pest exterminators or treated myasthenia gravis patients (those groups with continuous high exposures to these substances) have developed Gulf War-like illnesses. Furthermore, many veterans who were not exposed to these substances developed Gulf War-like illnesses. This includes a small, but not insignificant, number of non-deployed, vaccinated

soldiers. (The RAC's former scientific director did some of the seminal research in this area, finding GWS-like illnesses in more than 11% of GW-era soldiers vaccinated for deployment, but never deployed. [2]) Thus other exposures must also be involved.

The Report's research recommendations are sound. The compilations of data in the appendices provide valuable summary information.

These findings underscore the importance of our Commission's work, which is to do all in our power to help ill veterans and prevent future illnesses.

To Access the Complete Gulf War Illness Report:

http://sph.bu.edu/insider/images/stories/resources/annual_reports/GWI%20and%20Health%20of%20GW%20Veterans_RAC-GWVI%20Report_2008.pdf

Some areas that are under consideration for future recommendations at the Federal level are:

1. Military Physical Screenings:

   There is some debate as to the value of a physical exam as a preventive measure yet this issue remains a high priority with diverse opinions on the best approach to create safer healthcare practices and protocols for those serving in the military.

2. Vaccination Policies:

   Given the January 2007 Secretary of Defense Policy to alert Reserve Component Units twelve (12) months notice prior to deployment, the Commission will consider theater specific vaccinations that might be given in Maine. Recommendations on the immunization cycle to improve health standards may come out of this process.

   Vaccinations with the greatest possibility of adverse reactions are given just prior to deployment sometimes more than one at a time. In the military, it is allowable to give up to fifteen (15) vaccinations at one time. What if these could be given at 'home', one at a time, to soldiers with vaccination buddies and whose doctors and families have had education as to what to look for as signs of an adverse or allergic reaction? Treatment could begin immediately with a better chance of recovery.

3. Tracking Healthcare of All Military Service Personnel Returning to Maine from All Branches of the Service: This is a most complex issue with HIPAA rules and Federal jurisdiction just some of the challenges. One thought is that a sub-group of commission members and other stakeholders be formed to explore how this might best be accomplished. One possible outcome of studying this issue may be a recommendation for changes in HIPAA rules as well as advocating for changes in Federal Jurisdiction.

D. Propose and seek approval from the Armed Forces of the United States for the Maine National Guard to retain a copy of the medical records of each member of the Maine National Guard who is sent to active duty;

In deployments to date, Department of the Army Personnel Policy Guidance required that "soldiers deploying to overseas locations (OCONUS) will deploy with the Adult Preventive and Chronic Care Flowsheet, DD Form 2766" (the commonly referred to "Medical Field File"). The DD 2766 will be used as the deployment health record. Units/soldiers will not deploy OCONUS with health and dental records. Health and dental records will be returned to home station following mobilization/deployment processing. Records will be returned to the demobilization station for review during medical out-processing. Upon return from an OCONUS deployment, the DD 2766 will be reintegrated into the soldiers' medical record".

The Department of Defense is moving to an internet-based electronic health readiness record (HRR) which is a scanned collection of medical documents currently in the paper medical records. The system will operate 24 hours a day, seven days a week, is password secured and accessed only by authorized personnel, to include the individual service member. This will avoid the historical problem of records moving back and forth between mobilization station and home station and therefore possibly not being accessible in a timely fashion.

Maine Army National Guard medical records have been scanned, are currently being indexed and new documents are being scanned as they are received. The Maine Army National Guard has adopted a deadline of December 2008 to conduct quality control tests which will validate the HRR as operational.

There is a process in place at the federal level to go to electronic medical records and with the assurance, that until the completion this process, any soldier can get a copy of his/her military medical records upon request.

Maine National Guard Return Receipt Policy:

In recognition of the fact that non-AGR members of the Maine National Guard see civilian medical providers and in recognition of the fact that electronic medical records do not exist as a standard in the American medical system and in recognition of the fact that complete medical records are essential to ensure that members are properly evaluated upon discharge, the Maine National Guard will institute a policy that both encourages members to bring their civilian medical documentation in during their annual PHA and receive a receipt for the same.

The Adjutant General will issue a policy letter that establishes this as command policy and direct that the Maine National Guard Medical Command develop, procure and distribute a Return Receipt stamp that will be used to stamp incoming civilian medical documentation and require that the stamp be signed and dated indicating and establishing receipt.

This action will be completed NLT April 2009.

Background and Additional Information on "Return Receipt":

1. Problem: Lack of evidence from outside providers making it into Guard service member's medical records, thus affecting the Unit's ability to properly assess the medical readiness of the member. Also hurting the member when and if, they eventually file for service connection at the VA. This process improvement can help both the member and the unit.

2. Solution: Create an education process to inform the member of the importance of providing outside medical documentation to the unit.
    a. Draft and institute an instruction capturing this process improvement.
    b. Create a form, a receipt of documentation to be provided to the service member when documentation is provided.

3. Develop and ensure that training is provided:
    a. During post deployment training, stress how providing documentation about emerging health issues can eventually affect a members dealing with the VA should they need to prove service connection at a later date.
    b. During annual training provide a copy of the instruction, and a copy of the receipt, stapled to the annual physical checklist. Educating members about the importance of providing documentation.

E. Provide for the education of members of the Maine National Guard and other military personnel, especially medical staff, with respect to safer and more effective health care practices and protocols;

1. Education Programs Utilizing Maine Resources:

One way to increase the safety of the National Guard members is to educate them on the importance of sharing all medical information with their civilian medical providers. This could be done in many ways:

A wallet card with the dates of administration of different immunizations on it.

Each time a National Guard member is examined or receives any medical treatment remind them how important it is to share this information with other providers.

Remind each service member to ask for a copy of his/her medical record and pass it on to all of the providers.

Train members to identify themselves as National Guard members whenever going to a hospital.

There should also be an education program for civilian providers to remind them to ask each of their patients if they are a member of the National Guard. This would be very important for emergency room providers. The Maine Medical Association would be able to help with this.

Better education of the members of the National Guard is well within the realm of possibilities. The financial cost would be small and there would be no legislative obstacles. This could be put in place with little or no delay and could have a large impact if anyone were to have adverse reactions to any medical procedures such as immunizations.

2. Education Programs Utilizing Outside Resources:

Invite Colonel Renata Engler, M.D., the director of the Vaccine Health Care Center at Walter Reed Army Medical Center, and a worldwide presenter, to Maine, to teach the most current information on military vaccination protocols and safety to Maine National Guard doctors, soldiers, their families, commission members and civilian doctors. The Maine National Guard will also work to set up presentations in coordination with VA Togus and the Maine Medical Association to provide a broader audience.

Educate Maine National Guard Service Members and Families

Aside from the formal training service, members receive during drill weekends, annual training periods, formal training events, civilian and military schools, and deployments nationwide and overseas; numerous informational and educational resources and organizations reside within the Maine Army and Air National Guard. The Commission, in collaboration with the Maine National Guard, is committed to taking advantage of the following informational and educational resources and venues to maximize extremely important "commission related" information flow to education Maine National Guard service members and their families.

National Guard Deployment Cycle Support Yellow Ribbon Program:

The 2008 National Defense Authorization Act directed robust financial resources from which originated the Army National Guard Yellow Ribbon Program; a robust, preventive, proactive support program for Soldiers and Families. The intent of the program is to provide a continuum of care needed to ensure Soldiers and Families receive the care and services necessary throughout the entire deployment cycle. Maine is currently in the process of implementing this program including the following health related assistance and services to soldiers and their families;

1) Suicide prevention
2) Substance abuse awareness and treatment
3) Anger management counseling
4) Post traumatic stress disorder or traumatic brain injury
5) Rural health care reintegration
6) Veterans related centers, benefits, medical and other resource referral services

This newly developed Yellow Ribbon Program will improve how service and family members progress through the deployment cycle; and will promote family preparedness through education, by conducting family and service member outreach, forming partnerships and leveraging resources.

Maine National Guard Family Assistance Center (FAC);

The Maine National Guard Family Assistance Center represents another very active and outstanding family and service member educational resource. An ever expanding organization, the Maine National Guard Family Assistance Center maintains a very active and interactive website with numerous resources, benefits, referrals and links for service member and their families. The website is located at: http://www.me.ngb.army.mil/Family/default.htm

Additionally the Maine National Guard Family Assistance Center publishes and distributes periodical newsletters; The "Chain of Concern" and "Safety and Wellness" represent bi-monthly newsletters mailed directly to all Maine National Guard.

Maine National Guard Publications

Unit Newsletters:

The diverse structure of the Maine Guard (totaling approximately 3,300 service members) represents a complex organization of both Army and Air National Guard units arrayed across the State of Maine. Each month, unit leadership develops and mails newsletters containing unit specific military related information to each service member (and their families).

Guard ME Magazine

The Guard ME Magazine is a semi-annual magazine distributed to Maine Army National Guard members, their families and retirees. This publication highlights unit training events and important command messages from the Adjutant General and State Command Sergeant Major.

F. Assist the families of Maine National Guard members who died in military service from noncombat causes, including suicide, to obtain accurate and timely information in regard to the deaths of the Maine National Guard members;

Introduction to the Case Review Process:

In order to best serve families, who may have lost a loved one through a non-combat death; current members and veterans who have been injured or disabled from non-combat causes; a less daunting, more specific and more private process than testifying at a public hearing was identified as a need.

Thus, the Commission created its own Case Review Process, held a Trial Case Review with a disabled veteran who volunteered his assistance and is in the process of ensuring the privacy of those proceedings with proposed legislation for consideration during the 124th Legislative Session.

Case Review Process For The Commission to Protect the Lives and Health of Members of the Maine National Guard:

What is the Noncombat Death and Disability Case Review Board?

The Noncombat Death and Disability Case Review Board has been established to prevent future noncombat death and disability in the Maine Army National Guard, in a no-fault manner.

What is the role of the Noncombat Death and Disability Case Review Board (NDDCRB)?

The NDDCRB will listen to concerns and questions of family members or veterans who have suffered a noncombat death or disability. The NDDCRB will assist and advocate for the veteran or family in getting questions answered, actions taken, and problems resolved.

The NDDCRB will make recommendations for changes to the Commission to Protect the Lives and Health of Members of the Maine National Guard.

Who sits on the NDDCRB?

The NDDCRB will be multi-disciplinary, made up of 3 – 5 members with expertise or experiences best suited to listening compassionately and addressing the needs of the family or veteran, to be selected by the Chair.

The Chair of the Commission will chair or appoint a chair for the Board.

How does the NDDCRB ensure that recommendations are carried out?

The NDDCRB shall prepare and provide a report of the case review to the Commission and family or veteran within 3 months of the final session.

The Commission has the responsibility to see that recommended changes are made, if a state issue, or that recommendations for action be moved forward, if a federal issue or otherwise beyond the Commission's jurisdiction.

Report From A Trial Case Review:

A trial Case Review was held to help clarify and define the process. The task was to provide a safe space where confidentiality was to be respected, to listen, to offer support, to ask clarifying questions, to look not for fault, but for solutions.

The trial review was held June 13, 2008 in a meeting room at the public library in Brunswick, which was a more accessible location for the veteran. The review was chaired by the Chair of the Commission with several Commission members, an advisory member and related non-members participating. The veteran, whose case was being reviewed, volunteered to do so.

Issues Identified By The Veteran:

- He felt abandoned by his military 'family' once he determined his health was such that he must medically retire out.

- This veteran felt he was on his own to find his way through the MEB/PEB (Medical Evaluation Board) and appeal process. He perceived that he was now in an adversarial role with the military, his unit, the JAGs etc. and that was why he did not get help or support.

- Even though he was an officer, he experienced the healthcare and housing at Walter Reed as unacceptable. Not only did he not see a specialist, the only doctors he saw were residents.

- His military medical separation appeal process took four years (4) and left him feeling isolated, disempowered, and demoralized. He was not allowed into the hearing room and had just met the JAG who represented him.

- The percent of separation pay/disability awarded by the active duty side was very low and unsatisfactory to him.

- His process of separation/retiring out medically and then getting a diagnosis of MS with an acceptable level of disability from the VA took **eight (8) years,** was mind boggling and a physical challenge for someone physically and cognitively impaired.

Issues for Commission to consider for future Case Reviews:

- Compassionate listening is the most important aspect of this process.

- Confidentiality and protecting the privacy rights of families and the medical or other personal information that is shared in this process is critical.

Chair's impressions for Commission to consider:

- Compassionate listening requires not having an agenda so in most cases ex-officio members are not best suited for this task. It might be advisable to include other non-members, such as those with mental health and hospice backgrounds.

- Problems at Walter Reed predate recent news of unacceptable housing and continuity of care.

- Disability levels are usually raised significantly in percentage and more apt to be satisfactory to the soldier when they get into the VA system, but this process can also take years.

- Continual training and education is needed to ensure Maine Veterans' Services Representatives are up to date on frequently changing VA regulations. This will enable them to better serve their clients.

- Disabled soldiers caught in this bureaucratic system with no support and no apparent way out, might well view suicide as a 'solution'. Work to close the gaps in the system must continue, so that these individuals and their families feel/are supported.

- There are aspects of military culture that are detrimental to the health and healing of those who serve. Some examples: importance of fitness to the extent that running daily even in 100+ degree heat and at high altitudes is the norm; if a soldier has an injury not only may he/she cover it up, but may be encouraged to 'tough it out, not wimp out'; a "don't ask and don't tell" culture in the military extends to medical situations for a variety of reasons.

- The MEB/PEB process as described in this review sounds as if it is in opposition to the very values of our country that service members are asked to fight for and would be unconstitutional in the civilian world.

Suggested actions to be taken:

- Recommend there be an ombudsman-type position to advocate for active duty soldiers going through the medical disability process.

- Ascertain that ongoing training is being carried out by Maine Veteran's Services to ensure all representatives are updated of all the dynamic changes in regulations at the VA.

- Explore ways of protecting privacy of the individual including their identity, private circumstances and medical information.

Recommendations From the Attorney General's Office Pertaining to Protecting Confidentiality and Privacy Rights:

1. Receive confidential medical information in Executive Session pursuant to Section 405 of the Freedom of Access law and that personally identifying information will not be disclosed absent a disclosure authorized by law or through a properly executed release.

2. Ask the 124th Session of the Maine State Legislature to specifically spell out in statute how confidential information is going to be handled in this Commission's case review process.

3. Meet with the Right To Know Advisory Committee on November 17, 2008 to seek their guidance on the handling of medical information to protect privacy.

Update on Confidentiality and Protecting Privacy Rights:

Barbara Damon-Day, Chair and Peter Ogden met with the Right to Know Advisory Committee on November 17, 2008. As a result, legislation, specifically for the Commission case review process that protects confidentiality and privacy rights, was drafted by OPLA and has been forwarded to Colonel Don Lagace at Camp Keyes for inclusion in the Maine National Guard "housekeeping bill" for the upcoming 2009 Legislative Session.

Recommendation from the Case Review Board to the Commission:

That the Commission recommend an advocate for medical and psychological issues for all members of the military and their families. That the advocate be located in the Governor's Office and be a point of contact and referral to the appropriate resources, where follow-up will continue until a satisfactory outcome is reached in each case.
This recommendation is being put on hold because of serious budget shortfalls, improvements that already have been made to this process by the Maine National Guard and a current increase in support positions at Camp Keyes coming from the federal level and in some instances for all branches of service.

Language and Summary of Proposed Legislative Change to Protect Privacy:

Sec. 1. 22 MRSa §532, sub-§6 is enacted to read:

6. Case review; confidentiality. The commission may act as a panel to review cases involving Maine National Guard noncombat death and disability. When the commission or a subcommittee of the commission acts as a case review panel, the proceedings and records of the panel are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commission shall disclose conclusions of the review panel upon request, but may not disclose information, records or data that are otherwise classified as confidential.

SUMMARY

This bill/section authorizes the Commission to Protect the Lives and Health of Members of the Maine National Guard to act as a panel to review cases involving death or disability of members of the Maine National Guard. When the commission or a subcommittee of the commission acts as such a review panel, its proceedings and records are confidential and are not subject to subpoena, discovery or introduction in a civil or criminal action. Conclusions of the panel may be disclosed, but no confidential information may be released.

G. Provide for the cooperation and coordination of assistance between the Maine National Guard and the center for disease control with respect to this chapter;

Working with stakeholders, including the Commission's members, Maine CDC staff identified existing resources for returning Maine veterans, including National Guard. These resources were compiled, and a web page was created for them, called the Veterans Resources web page. The link to this page was widely circulated by email and posted on the Maine CDC's homepage, which receives over 5,000 visits per month. The direct link is: http://www.maine.gov/dhhs/boh/veterans_resources.htm; and the homepage of the Maine CDC is: www.mainepublichealth.gov.

The Commission will provide guidance as these two agencies explore ways "to coordinate and cooperate to provide a higher standard of preventive health care for members of the Maine National Guard".

Maine National Guard and the Maine Center for Disease Control Cooperation and Coordination Efforts:

The Commission to Protect the Lives and Health of Members of the Maine National Guard provides oversight for the part of the statute that "directs the Maine National Guard and the Maine Center for Disease Control to take such actions as necessary to accomplish these purposes including coordination and cooperation between these two agencies". The efforts of such interagency coordination and cooperation are reflected in the following collaborative endeavors.

Maine CDC and the Maine's Bureau of Veterans' Services conducted an analysis of Veterans' Survey Data. This survey provided significant base-line information for follow on surveys. The

two departments have committed to conducting another survey in 2010 and subsequently will report post-implementation veteran health-care feedback and analysis to the Commission.

Maine CDC established a direct link on their website to a variety of resources for Maine veterans and their families including the following;

Chaplains
Counseling Services
Department of Veterans Affairs Resources
Education Benefits
Help for Families
Hotlines
Medical Information
Mental Health
Military Health Insurance
Re-Employment Issues
Vaccine Information
Veterans Centers
VA/Maine Veterans Services

This valuable collaboration effort between Maine CDC and the Department of Defense Veterans and Emergency Management represents a dynamic on-going resource integrating valuable information to Maine's veterans, service members and their families. The website is accessible via the following hyperlink;

http://www.maine.gov/dhhs/boh/veterans_resources.htm

These two departments continue to achieve momentum in contemporary medical initiatives. The Maine Army National Guard State Surgeon is coordinating two specific future medical venues in Maine (a Web Cast and a personnel seminar) from U.S. Army Colonel and an immunologist at the Walter Reed Army Medical Center in Washington, Dr. Renata Engler. Dr. Engler will provide an overview of vaccine related issues and updates as well as suggestions of what medical professionals should look for. Medical personnel from the Maine Medical Association, the University of Maine, Maine's Center for Disease Control, the Maine National Guard, Veterans Affairs and other medical professionals represent the intended audience.

H. Work with the Bureau of Maine Veterans' Services to track the care of the physically and psychologically wounded Maine National Guard and Armed Forces service members from Maine within the health care systems of the United States Department of Defense and the United States Department of Veterans Affairs and serve as an advocate to ensure a high quality of care; and

Tracking Medical Status of Service Members

1. What is being done now:

   a. Maine Veterans' Services does track all Maine service members who have died while deployed in support of combat operations since September 11, 2001.

b. MVS has developed a spreadsheet to track identified types of illnesses experienced by Persian Gulf and Global war on Terror veterans. (Appendix 9)

c. MVS has developed cover letter and questionnaire to be given/sent to returning veterans asking for their help in identifying illnesses attributed to their service in the military. (Appendix 10)

2. Short term goals:

a. The Maine Attorney General will provide advice/instruction to the Commission on the legal aspects of certain state agencies requesting, compiling, and storing medical data provided by service members and/or their families to the Commission.

Status: The AG's Office met with the Commission and provided information and assistance in understanding current Maine laws pertaining to HIPPA. AG's Office assisted Commission in meeting with the Maine Right to Know Committee to discuss the privacy requirements and they recommended draft language to be placed in law that allows the protection of all private information given to the Commission. Legislation will be heard in upcoming legislative session (Jan-Apr 2009).

b. The Commission will send a letter to the families of those National Guard members who have died to ask the families to participate by providing the Bureau of Maine Veterans Services a copy of:

(1) DD-1300, Casualty Report
(2) DD- 2064, Certificate of Death
(3) Military records of awards/decorations and assignments

Status: **Commission will send letter (September 2009) once the law becomes effective that protects the information provided by the families**

3. Long term goals:

a. Compile data.

b. Review data periodically with appropriate personnel to identify any trends that may develop.

Status: State Medical Examiner, Dr. Greenlaw, and MVS Director reviewed what data was available and no trends were identified. Will continue to compile data and review on at least an annual basis.

c. Notify appropriate agencies of any trends noticed/identified

d. Expand database to include veterans of the Persian Gulf War (discharged since 1990) that want to participate.

Status: Data from first Gulf War veterans being compiled currently.

e. Expand database to include those who have been discharged since 1990 and/or have died of unexplained causes. Work with State Medical Examiner to define these cases. The Office of Chief Medical Examiner will add a data element to their database beginning with cases after January 2008. This field will be used to track military service as reported by families to their funeral director. This information is received in the Office of Chief Medical Examiner after the death certificate is filed in Vital Records and then returned to Bureau of Veterans Services. This process takes approximately 3-4 months. It must be noted that the data from the Office of Chief Medical Examiner is limited to the deaths which fall under their jurisdiction by statute and that these deaths account for only approximately 10% of Maine deaths each year.

Tracking Medical Status of Service Members

1. What is being done now:

   a. Maine Veterans' Services does track all Maine service members who have died while deployed in support of combat operations since September 11, 2001.

   b. Review other states for similar programs.

2. Short term goals:

   a. The Maine Attorney General will provide advice/instruction to the Commission on the legal aspects of certain state agencies requesting, compiling, and storing medical data provided by service members and/or their families to the Commission.

   b. The Commission will send a letter to the families of those National Guard members who have died to ask the families to participate by providing the Bureau of Maine Veterans Services a copy of:

      (1) DD-1300, Casualty Report
      (2) DD- 2064, Certificate of Death
      (3) Military records of awards/decorations and assignments

   c. Maine Veterans Services and certain state agencies will develop tracking format.

   d. Develop survey questionnaire for service members to complete.

3. Long term goals:

   a. Compile data

b. Review data periodically with appropriate personnel to identify any trends that may develop

c. Notify appropriate agencies of any trends noticed/identified

d. Expand database to include veterans of the Persian Gulf War (discharge since 1990) that want to participate.

e. Expand database to include those who have been discharged since 1990 and have died of unexplained causes. Work with State Medical Examiner to define these cases.

The Office of Chief Medical Examiner will add a data element to their database beginning with cases after January 2008. This field will be used to track military service as reported by families to their funeral director. This information is received in the Office of Chief Medical Examiner after the death certificate is filed in Vital Records and then returned to Maine Veterans Services. This process takes approximately 3-4 months.

Once enough data is available, it is anticipated that Peter Ogden, Department of Veteran Affairs will provide a list of deceased veterans and their times and location of active duty service so that we can begin to cross-reference types of death with that information. We have not yet determined whether the data will be redacted for personal information or whether the Department of Veterans Affairs may wish to obtain family permission to review all of the information about the specific deaths.

It must be noted that the data from the Office of Chief Medical Examiner is limited to the deaths which fall under their jurisdiction by statute and that these deaths account for only approximately 10% of Maine deaths each year.

Maine Veterans Brief Health Profile
Maine CDC/DHHS, September 2008

Source: 2006-2007 two-year compilation of BRFSS (Behavioral Risk Factor Surveillance Survey), a telephone survey conducted by the Maine CDC of about 5,000 adults in Maine annually.

Proportion of the Adult Population Who Identify Themselves as Veterans

US	12%	(~1 in 8)
ME	15.5%	(~1 in 6)

Of Maine men, 30% are veterans.
Of Maine women, 2% are veterans.

30% of Maine adults 65 and older are veterans,
whereas 12% of Maine adults 18-64 are veterans.

Veterans By County:

Androscoggin	18%	Oxford	19%

Aroostook	15%	Penobscot	13%
Cumberland	13%	Piscataquis	19%
Franklin	13%	Sagadahoc	19%
Hancock	14%	Somerset	16%
Kennebec	18%	Waldo	16%
Knox	14%	Washington	18%
Lincoln	16%	York	16%

Some Health Data of Veterans vs. Non-Veterans (**bold** lettering refers to those data that are significantly different between veterans vs. non-veterans):

Income
23% of veterans earn <$25,000 annually vs. 25% of non-veterans
42% of veterans earn >$50,000 annually vs. 44% of non-veterans

Education
5.5% of veterans have less than a high school education, vs. 7.4% of non-veterans
32% of veterans have a college degree or higher, vs. 35% of non-veterans

Employment
Veterans are more likely to be not employed ("not employed" includes retirement)
53% of veterans are employed vs. 64% of non-veterans

Marital Status
75% of Maine veterans are married vs. 64% of non-veterans

General Health Status
-52% of veterans describe their health as excellent or very good, vs. 60% of non-veterans

-18% of veterans describe their health as fair or poor, vs. 13% of non-veterans

+77% of veterans have had a check up in the last year, vs. 70% of non-veterans

7% of veterans said they could not get medical care because of costs, vs. 10% of non-veterans

+92% of veterans have health insurance, vs. 88% of non-veterans

87% of veterans have a primary care provider vs. 89% of non-veterans

30% of veterans report being disabled, vs. 22% of non-veterans

-15% of veterans say their physical health was not good at least 14 days in the past month, vs. 11% of non-veterans

9% of veterans reported frequent mental distress, vs. 10% of non-veterans

19% of veterans report not having emotional support, vs. 16% of non-veterans

49% of veterans report being very satisfied with their lives, vs. 48% of non-veterans; and 5% of both populations report being dissatisfied with their lives

18% of veterans 65+ report a fall in the past 3 months, vs. 17% of non-veterans

4% of veterans appear at risk for suicide, vs. 3% of non-veterans

7% of veterans report moderate/severe depression, vs. 8% of non-veterans

13% of veterans report anxiety vs. 17% of non-veterans

-12% of veterans report having diabetes, vs. 7% of non-veterans

+7% of veterans report having asthma, vs. 11% of non-veterans

-18% of veterans report having cardiovascular disease, vs. 7% of non-veterans

-42% of veterans report having arthritis vs. 30% of non-veterans

-42% of veterans report having high blood pressure, vs. 26% of non-veterans

-50% of veterans report having high cholesterol, vs. 38% of non-veterans

+9% of veterans report not having their cholesterol checked in at least 5 years, vs. 21% of non-veterans

-72% of veterans are overweight or obese, vs. 59% of non-veterans

20% of veterans are smokers vs. 21% of non-veterans

15% of veterans binge drink vs. 16% of non-veterans

6% of veterans are heavy drinkers vs. 6% of non-veterans

75% of veterans have had their teeth cleaned within the past year, vs. 72% of non-veterans

-66% of veterans have had some or all (12%) of their teeth removed, vs. 46% (and 7% all teeth) for non-veterans

-74% of veterans have exercised regularly in the past month, vs. 80% of non-veterans

+54% of veterans 65 and older have had a flu shot in the past year, vs. 36% of non-veterans

+44% of veterans 65 and older have had a pneumonia shot, vs. 23% of non-veterans

89% of veterans 50 and over have had a colonscopy/sigmoidoscopy colon cancer screening in the past 5 years, vs. 87% of non-veterans

+72% of veterans >50 have had a PSA test vs. 67% of non-veterans

62% of veterans with diabetes have taken a diabetes management class, vs. 62% of non-veterans

46% of veterans meet the moderate exercise guidelines, vs. 46% of non-veterans. 11% of both groups report no regular physical exercise.

-25% of veterans report eating at least 5 servings of fresh fruits and vegetables per day, vs. 29% of non-veterans*

Mammogram and Pap Smear rates insufficient sample size to determine

To Explore Funding For A Quantitative Analysis of Those Suffering Gulf War Syndrome In Maine: This would be an epidemiological assessment in a relatively small but accessible population. The study would look at: (a) recent deaths, for trends in cause (b) Gulf War Veteran's illnesses for symptoms and treatments (c) best treatment practices, then to validate those practices (d) making recommendations for prevention.

To Seek A Grant for A Gulf War Treatment Trial Which Has Already Been Designed and is Available to Commissioner

I. Assist the Maine National Guard in ensuring appropriate demobilization procedures and follow-up for Maine National Guard members related to mental health issues, including, but not limited to, substance abuse and post-traumatic stress disorder.

The following is the summary of what we, the Maine National Guard, are doing in the State about suicide prevention, and intervention:

1. We have one Unit Ministry Team that is certified to conduct Applied Suicide Intervention Skills Training (ASIST). By February 19, 2009, we will have two teams certified to conduct this training. We will ramp up to conduct more classes to fill the needs of the units going "out the door."

2. The current ASIST training team has trained over 70 personnel state-wide to conduct direct interventions. These personnel include a cross-section of the command structure, from O6 to E4, drilling at various armories. This number also includes 3 members of the Family Assistance Center staff that man the 1-888 line.

3. Chaplains are the "Gatekeepers" of the suicide prevention program. All our chaplains have received ASIST training.

Chaplains are charged with the following:

a. Provide direct intervention to soldiers in crisis

b. Monitor morale and stress in the units and give commanders feedback about issues that directly affect the morale and mental wellbeing of the command.

c. Provide direct support to commanders, soldiers, and family members when a soldier expresses suicidal ideations, attempts suicide, or completes suicide.

d. Provide annual Suicide Prevention training to all members of the Guard using the Army Suicide Prevention Program, a program developed for the Army by the United States Army Center for Health Promotion and Preventive Medicine (USACHPPM).

NATIONAL GUARD DEPLOYMENT STRESS MITIGATION PROGRAM

The Problem - When Reserve Component Service Members (Army or Air National Guard, or Army, Navy, Marine Corps Reserve) return from an extended deployment with Active Duty Armed forces, they face many challenges re-integrating with their civilian lives. The separation from family, friends, and familiar places and constant pressure of being in a combat environment cause stress reactions, which are sometimes delayed until the Service Member (SM) returns home. The greater the stress within that family and/or in the work place, the more likely that the adjustments that the SM must make could be delayed or bring about inappropriate reactions. The physical, mental and emotional challenges that our law enforcement officials, first responders, and corrections officers face on any given day can only multiply the possibility that they will have exaggerated reactions due to delayed stress reactions resulting from their deployment. Our responsibility as leaders is to ensure the safety and appropriate actions of these employees and the public they serve.

The Process - Right now, the Maine Army National Guard has a process for all returning soldiers; this program is also available to the various reserve units and individual Active Duty returnees, but it is not mandatory for them. Here is our program for deployments:

BEFORE:

1. We hold periodic, mandatory Stress Awareness and Reduction briefings at Weekend Drills

2. We hold soldier and family preparation briefings, just prior to deployment

DURING:

1. Periodic communications with unit commanders to identify potential soldier/family problems

2. Quarterly meetings with family members to inform them of unit activities and time schedules, to answer their questions, and to provide a time of fellowship

3. Active Duty Combat Stress Teams in country with the soldiers to meet immediate needs of soldiers facing trauma or other stress inducing situations
4. Active Duty Chaplains to provide spiritual and personal guidance for the soldiers

5. Full-Time Support Chaplain(s) to provide support to families

6. One month prior to return of soldiers, provide preventative briefings to family members to provide reintegration training, resources, and awareness

7. Soldiers go through the Post Deployment Health Assessment (PDHA) within 30 days of return to home station.

8. Soldiers go through Deployment Cycle Sustainment (DCS) training, while still in country, then back at their demobilization station which also prepares them financially, personally, and administratively to return home. This includes awareness of potential mental health and/or behavioral issues.

AFTER:

1. Upon return of our soldiers to Maine, they have a one to two day in-State demobilization process which gives them training and resources for their readjustment to home; this includes a 1 on 1 meeting with a qualified counselor from the VET Centers, as well as providing them with resources for military or civilian behavioral and mental health counseling

2. Each soldier receives a monthly call from our Family Assistance Centers for three months following deployment to check on issues, concerns or the lack thereof

3. 30 days after deployment a "social" weekend drill is offered where families are encouraged to attend and the focus is on the fellowship opportunity for soldiers who might not have seen each other since returning home. Resources for medical and emotional support are offered here as well (this is in a paid status, but is voluntary)

4. 60 days after deployment there is a similar offering to the 30 day event

5. 90 days after deployment is the first mandatory drill for the returning soldiers. Here they will usually have a Department of Defense mandated survey known as the Post Deployment Health and Risk Assessment (PDHRA) which attempts to identify any medical, mental, or emotional issues. In addition, we have a series of briefings and interactive sessions with trained counselors from the VET Centers, focused on normalization of experience and identification of more severe problems

Pre and post deployment screenings for Traumatic Brain Injury Screening (TBI) are currently being given to all deploying Maine National Guard soldiers through a grant from Maine Health Access Foundation in partnership with Dartmouth Medical School.

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

IL 10-2006-004
In Reply Refer To: 11A

January 25, 2006

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

SCREENING AND CLINICAL MANAGEMENT OF TRAUMATIC BRAIN INJURY

1. Purpose. This Information Letter provides guidance to the Department of Veterans Affairs (VA) primary care clinicians on how to identify and initiate clinical management of Traumatic Brain Injury (TBI) in veterans and eligible active duty service members.

2. Background

a. In peacetime, more than 7,000 Americans diagnosed with TBI are admitted to military and veterans' hospitals yearly. During times of combat, TBI admissions increase significantly. Historically, between 14 and 20 percent of surviving casualties of armed conflicts are left with TBI. A recent perspectives article in the New England Journal of Medicine (Okie, NEJM, 2005; 352(20):2043-2047) noted that 59 percent of blast exposed patients from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) admitted to Walter Reed Army Medical Center had brain injury. As members of the Armed Forces return from engagements in Afghanistan and Iraq, it is anticipated that some will exhibit symptoms of TBI that may not have been diagnosed prior to demobilization. Given the high rate of exposure to conditions that may cause TBI, it is important that VA clinicians maintain a low threshold to suspect TBI and to initiate its management.

b. While the nature and outcomes of brain injuries resulting from blast exposure are not yet fully understood, it is important to recognize that brain trauma causes both acute and delayed symptoms. Each requires prompt identification and multidisciplinary evaluation and treatment. Providing specialized health care for military personnel and veterans sustaining a brain injury continues to be a high VA priority.

3. Evaluation and Treatment

a. Veterans and active duty service members with TBI recognized at the time of injury benefit from care provided at specialized Department of Defense (DOD) and VA TBI Centers.

Less severe brain injuries may not become evident until military personnel return home to the care of their community physicians, DOD, or VA medical centers. Complicating prompt diagnosis is the fact that many who receive this type of brain injury do not recall the trauma that caused it. As a result of amnesia, patients may not be able to volunteer a history of head injury to link to their symptoms. Therefore, in some cases, it may be necessary to ask directly about head injury, and in others, to determine by inference (e.g., patient woke up in a hospital after having been thrown from a vehicle) that a head injury may have taken place.

b. Common symptoms found in the post-acute phase include physical problems with motor strength and coordination, post-traumatic headaches, pain, dizziness, fatigue, sleep disturbances, muscle spasms, seizures, and visual and vestibular impairments. In addition, patients may experience cognitive and personality changes, such as exhibiting new learning and memory deficits, impaired ability to attend and concentrate, diminished executive control, problems communicating, impaired judgment and insight, poor impulse control, difficulty controlling physical aggression, persistent irritability, mood liability, depression, and substance abuse. These impairments may make reintegration into civilian life and return to family and work problematic. Appropriate assessment and treatment can help with long-term outcomes.

c. Individuals presenting with symptoms such as these need to be evaluated for TBI. They may need referral to physical medicine and rehabilitation, mental health, clinical neuropsychology, or neurology services, or they may need to undergo brain imaging, such as by Magnetic Resonance Imaging (MRI). Clinicians need to discuss with families and caregivers the role TBI may play in causing the veteran's personality and cognitive changes. Long-term treatment is likely to require continuation of multidisciplinary care and case management.

NOTE: *For more details about the diagnosis and treatment of TBI, see Veterans Health Initiative, Traumatic Brain Injury: A CME Program which can be found at: http://www.va.gov/vhi*

d. Extra caution needs to be exercised in pharmacological management, as patients with brain injury are more sensitive to medication side effects. Clinicians need to avoid agents likely to decrease or slow cognition or that may cause adverse side effects in this vulnerable population. Pharmacological treatment needs to be tailored to individuals with TBI. Before starting a medication, clinicians need to ensure new symptoms are not due to environmental stressors (e.g., caregiver conflict, sleep cycle disruption). Pharmacological treatment needs to start at low doses, with increased attention given to drug toxicity and drug interactions. Use of benzodiazepines, anticholinergics, or antidopaminergics need to be minimized as they may exacerbate cognitive dysfunction. Over the counter products containing caffeine or claiming to improve energy should be avoided, because their use has been linked to episodes of mania, aggression, or hypertensive crisis.

e. While TBI is a relatively common occurrence, evidence-based guidelines for diagnosis and treatment are limited. Current practice is based on expert opinion. Given the high rate of exposure to conditions that may cause TBI, it is important that primary care clinicians routinely screen for its occurrence. Patients with TBI remain at high risk for development of delayed symptoms. A comprehensive assessment and treatment plan needs to be pursued if such symptoms are present. To help develop such a plan, primary care providers need to consider

referring patients likely to have TBI to physiatrists, clinical neuropsychologists, neurologists, or mental health professionals.

Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 1/26/06
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 1/26/06

Mental Health and Posttraumatic Stress Disorder (PTSD): In 2006, a study was done with Maine National Guard to investigate the mental health needs of returning veterans resulting in changes in the Maine National Guard Stress Mitigation Program, including one-on-one counseling.

Additional Issues that Have Been Identified:

Unique Opportunity for Maine: Maine has an incredible opportunity to be at the forefront of change nationally with this law. To our knowledge, no other state has passed this type of Legislation and directed such a diverse group of stakeholders to work toward making changes and recommending ways to better protect the lives and health of its citizen soldiers, who so willingly serve their state and nation.

Importance of Outreach: Without funded positions for outreach, it is a challenge, especially with a military population, to get the input from veterans so necessary to this process. It is clear that the current method of press releases and posters has not brought forth the volume of response anticipated at Public Hearings from veterans and their families who have suffered non-combat deaths and disabilities. Also, it has become clear that a soldier will not testify about an ailment that might end their military career. One suggestion was to align with existing 'town meeting' formats and to attempt to capture veterans issues in a more local and informal setting.

The Desire to Serve at Any Cost: There is a culture in the military that sometimes works against efforts to prevent death and disability. It is often the strong desire to serve that keeps soldiers from being forthright about their health issues, both mental and physical. This can occur at any time but is especially critical before and following mobilization. With HIPAA rules in place, Maine National Guard troops do not have to share their civilian medical records with the military doctors. Both these and other issues can result in soldiers being deployed who were not medically qualified in accordance with A.R. 40-501. Maine has not been granted an exemption to A.R. 40-501, so it can be assumed that it must be adhered to.

Commission Staffing Challenges: The preparation for the initial meetings took place without staff assistance from either Department of Defense, Veterans and Emergency Management and the Maine Center for Disease Control. Then a different person from Camp Keyes was sent each meeting to take minutes which were not distributed until the next meeting. Since the Preliminary Report, there is a capable person from Camp Keyes assigned to take minutes which are now distributed for review and changes directly following the meeting. Progress has been made in this area.

However, in spite of different strategies put in place, some of the contributors to the reports do not meet the timelines, with some submissions coming in as late as 3 working days prior to statutory delivery date to the Governor. This puts undue pressure on the Chair and Camp Keyes staff person. Who is expected to print and bind the report for delivery.

Reimbursement for Per Diem and Mileage: The first reimbursement for per diem or mileage was paid by Maine Center for Disease Control in April 2008, after four meetings. Since that time, payment has been handled in a more timely fashion.

A Staffing Recommendation From the Chair: When the Legislature establishes Commissions without specific staffing or funding, it places an additional burden on existing agencies who already may be experiencing diminishing time and resources. This can place the Chair of the Commission in an adversarial position with the very agencies she/he is attempting to work with and may decrease the productiveness and effectiveness of the Commission.

Appendixes

Appendix 1: Maine Center for Disease Control and Prevention Website

RESOURCES FOR MAINE VETERANS, SOLDIERS AND THEIR FAMILIES
provides links to a variety of resources for Maine veterans and their families.

Link: http://www.maine.gov/dhhs/boh/veterans_resources.htm

Website Contents
Chaplains
Counseling Services
Education and Education Benefits Office
Help for Families
Hotlines
Medication Information
Mental Health
Military Health Insurance
Re-Employment Issues
Vaccine Information
Veterans Centers
VA/Maine Veterans Services

Chaplains	
(Army) Chaplain Gibson	626-7872
(Army) Chaplain Vigue	474-7178
(Army) Chaplain Weigelt	626-7872
(Army) Chaplain Sivret	454-3942
The Maine Air National Guard maintains a full-time Chaplain Team. While the primary mission is to support the Airmen providing on-time refueling for US and Allied force aircraft, all requests for assistance will be promptly and courteously enquired into. If we cannot meet the need ourselves we will help the military member or their dependant resource those who can. The following are the Chaplain Teams' office phone numbers:	
(Air) Chaplain Dickinson	990-7242 / 356-0674
(Air) Chaplain Bach	949-2659
DSN 698-7242	
COM (207) 356-7242	
24/7 CELL (207) 356-0674	

Counseling Services
Military OneSource Hotline: 1 800-342-9647
Army OneSource Hotline: 1 800-464-8107
Community Counseling Center Hotline: 874-1030
NAMI Maine Hotline: 1 800-464-5767
DHHS Office of Substance Abuse: Bill Lowenstein: 287-6484

Education Opportunities and Education Benefits Office: 626-4370

Help for Families	
Center for Grieving Children: 775-5216	
Harland Turner Family Counseling/Maine Children's Home for Little Wanderers: 873-4253	
Maine Army National Guard Family Program	
Toll Free Hotline 1 888 365-9287	Website Maine National Guard Family Assistance Center
Maine Army National Guard Medical Information and Resources	
Website Medical Information Links	
Family Assistant Centers**:** 1 888-365-9287	
DHHS (Joan Smyrski): 287-8769	

Hotlines

2-1-1 Maine is part of a national movement to centralize and streamline access to health and human service information and resources. Just dial 211 or visit the 211 website at http://www.211maine.org/index.asp

Statewide Crisis Hotline: 1-888-568-1112

A statewide crisis hotline connects callers to the crisis service provider in the area from which they are calling. This line is for ALL individuals in crisis to provide immediate, local assistance in any crisis situation.

Other Hotlines

National Suicide Prevention Hotline: 1 888-273-TALK (8255)

Military OneSource Hotline: 1 800-342-9647

Army OneSource Hotline: 1 800-464-8107

Community Counseling Center Hotline: 874-1030

NAMI Maine Hotline: 1 800-464-5767

Medication Information

U.S Food and Drug Administration: Center for Drug Evaluation and Research
www.fda.gov/CDER/Drug/default.htm#Prescription%20Drug%20Information

Military Health Insurance

Martin's Point Health Care - the TRICARE network in Maine. Martin's Point is a diverse health care company that offers both health plans and primary care.

Website: Martin's Point

Martin's Point Phone: Tom Breault: 1 800-431-0777, x4458

Tri-Care (TAMP) Phone: Sheri Corriveau: 626-4407

HealthNet Services: Deb O'Brien: 798-8800

Re-Employment Issues

ESGR, MAJ Steve Hatt: 626-4282

US Department of Labor - VETS, Mr. John Guay: 753-9090

Togus Mental Health Clinic: 1 877 421-8263

Vaccine Information from U.S. CDC

www.cdc.gov/vaccines/pubs/vis/default.htm

Veterans Centers

Maine has 5 Veterans Centers in the state, located in Caribou, Bangor, Lewiston, Portland and Sanford. These centers also offer Readjustment Counseling Service and have been in existence since 1979. This program provides readjustment counseling to any veteran who served in a war zone and their family as it pertains to the Veteran's readjustment issues.

Veterans who were sexually assaulted or harassed while on ACTIVE DUTY are also served.

Bereavement services to the immediate family members of any serviceperson killed on active duty is also provided.

Below is a phone list of the centers; vets can call for an appointment and are seen quickly:

Caribou Charles Smith, Team Leader 207 496-3900	**Bangor** Ralph Grover, Team Leader 207 947-3391
Lewiston Roy Driver, Team Leader 207 783-0068	**Portland** Patricia Riker, Team Leader 207 780-3584
Sanford Amy Marcotte, Team Leader 207 490-1513	

VA/Maine Veterans Services	
VA Togus	
Jim Doherty	623-5714
Jim Hammond/Bobbie Hayden/Kathy Russen	623-8411
VA Benefits Office	
Charles Pervier	1 877-421-8263, x4939
Lisa Green	1 877-421-8263, x5062

Bureau of Veterans Services

This website contains resources for various state and federal benefits.
Bureau of Maine Veterans Service

Appendix 2: Bangor Daily News, February 20, 2008 article by Meg Haskell – *Troops' Brain Function Targeted*

Troops' brain function targeted

By Meg Haskell
Wednesday, February 20, 2008 - Bangor Daily News

All members of the American armed forces will soon have their brain functions tested and recorded before and after deploying to a war zone, courtesy of federal legislation co-written by U.S. Sens. Susan Collins of Maine and Hillary Clinton of New York. The testing is seen as an important step toward recognizing and treating traumatic brain injury, or TBI, widely considered the "signature injury" of the war in Iraq and, increasingly, in Afghanistan as well.

Getting a jump on the federal policy, the Maine Army National Guard already has started testing soldiers' brain function before deployment, perhaps the first group of "civilian soldiers" to generate computerized records of their cognitive performance.

Estimated rates of service-related traumatic brain injury, also known as concussion, vary, but some say that as many as 15 percent of all troops who have deployed to Iraq are affected. The physical trauma occurs most often when troops are the targets of roadside explosives or suicide bombers. The force of the explosion causes the brain to hit forcibly against the inside of the skull. The injury may be intensified inside soldiers' protective metal helmets.

The most severe cases of TBI may be marked by visible wounds to the head and may cause irreversible and life-changing losses of brain function. But mild to moderate cases often are unaccompanied by any outward indication and may go unrecognized and untreated.

In the absence of a clear diagnosis, the physical damage of TBI may easily be confused with the psychological response of post-traumatic stress disorder, or PTSD, another common consequence of wartime violence. Both conditions can cause loss of concentration, trouble with language or numerical concepts, intrusive thoughts, depression, irritability and aggression.

The new policy of testing brain function throughout the active-duty military is authorized in the federal Heroes at Home Act. President Bush signed the measure into law in January, and servicewide testing is mandated to be included as part of the routine pre-deployment medical assessment beginning April 1.

The computerized testing program asks subjects to perform tasks designed to measure memory, distractibility, word discrimination, eye-hand response and other aspects of brain function. Since different areas of the brain are responsible for different functions, changes in performance on the test will alert clinicians to areas that may have been damaged.

Treatment, which typically includes rest, medications and graduated rehabilitation exercises, is targeted to restoring the specific functions that have been lost or altered.

In a telephone interview on Tuesday, Collins, who serves on the Senate Armed Services Committee, said her interest in TBI was piqued by a conversation with Rockport neurologist Bruce Sigsbee, who was at the time treating a former service member for TBI. His patient had initially been diagnosed with PTSD.

Sigsbee persuaded Collins that the best way to determine the presence of TBI and to differentiate it from PTSD was to establish each service member's "baseline" brain function before deployment, and to repeat the test after deployment to see if changes are evident.

Collins said she had heard of a case in which a surgeon was deployed and came back having lost the ability to perform medical procedures.

"He didn't realize he had TBI," she said, "but that kind of loss would have been picked up" by the routine testing.

Collins noted that TBI is nothing new for combat troops, but Iraq is the first war zone where the use of roadside explosive devices has been the prevailing form of attack, and worsening conditions in Afghanistan portend an increase in TBI cases from that area as well.

The federal legislation also calls for support and training for family members caring for service members with TBI, and authorizes the Department of Veterans Affairs and the Department of Defense to explore the feasibility of using telemedicine to assess the brain function of troops still in the field who have suffered a head injury while deployed.

Testing of some active-duty troops already has begun.

Separately, the Maine Army National Guard began testing troops late last year in preparation for deployments in January to Iraq and Afghanistan.

Dr. Patrick Tangney, the chief medical officer for the Maine Army National Guard, said Tuesday that about 200 soldiers took the approximately 40-minute test, using a computer cluster at Husson College in Bangor. The testing was voluntary, he said, but to the best of his knowledge no soldiers declined.

The Maine Army National Guard project is funded with a three-year grant from the Maine Health Access Foundation and is being carried out in partnership with a head injury specialist at Dartmouth Medical School in New Hampshire.

Tangney said some people will always be "uncomfortable" with the idea of having their brain function mapped, and that military culture has traditionally promoted a "suck it up and don't be a baby" mentality when it comes to psychological or physical injuries.

But the wars in Iraq and Afghanistan are giving rise to new awareness of and respect for PTSD and TBI, he said, since improved body armor and other equipment has allowed many troops to survive injuries that would have killed them in previous conflicts.

The goal of the testing program, he said, is to ensure that Guard members returning from combat can make the transition safely to civilian life.

Tangney said testing of Maine Army Guard troops will continue until it's clear the federal program is effective and consistent.

"We're going to go ahead until the bigger system catches up with us," he said.

The Maine project, thought to be the only state-level program of its kind, also includes funds for training mental and physical health care providers in the treatment of traumatic brain injury.

mhaskell@bangordailynews.net

990-8291

Appendix 3: Department of Veterans Affairs Information Letter, January 25, 2006 Screening and Clinical Management of Traumatic Brain Injury

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

IL 10-2006-004
In Reply Refer To: 11A

January 25, 2006

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

SCREENING AND CLINICAL MANAGEMENT OF TRAUMATIC BRAIN INJURY

1. Purpose. This Information Letter provides guidance to the Department of Veterans Affairs (VA) primary care clinicians on how to identify and initiate clinical management of Traumatic Brain Injury (TBI) in veterans and eligible active duty service members.

2. Background

a. In peacetime, more than 7,000 Americans diagnosed with TBI are admitted to military and veterans' hospitals yearly. During times of combat, TBI admissions increase significantly. Historically, between 14 and 20 percent of surviving casualties of armed conflicts are left with TBI. A recent perspectives article in the New England Journal of Medicine (Okie, NEJM, 2005; 352(20):2043-2047) noted that 59 percent of blast exposed patients from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) admitted to Walter Reed Army Medical Center had brain injury. As members of the Armed Forces return from engagements in Afghanistan and Iraq, it is anticipated that some will exhibit symptoms of TBI that may not have been diagnosed prior to demobilization. Given the high rate of exposure to conditions that may cause TBI, it is important that VA clinicians maintain a low threshold to suspect TBI and to initiate its management.

b. While the nature and outcomes of brain injuries resulting from blast exposure are not yet fully understood, it is important to recognize that brain trauma causes both acute and delayed symptoms. Each requires prompt identification and multidisciplinary evaluation and treatment. Providing specialized health care for military personnel and veterans sustaining a brain injury continues to be a high VA priority.

3. Evaluation and Treatment

a. Veterans and active duty service members with TBI recognized at the time of injury benefit from care provided at specialized Department of Defense (DOD) and VA TBI Centers.

Less severe brain injuries may not become evident until military personnel return home to the care of their community physicians, DOD, or VA medical centers. Complicating prompt diagnosis is the fact that many who receive this type of brain injury do not recall the trauma that caused it. As a result of amnesia, patients may not be able to volunteer a history of head injury to link to their symptoms. Therefore, in some cases, it may be necessary to ask directly about head injury, and in others, to determine by inference (e.g., patient woke up in a hospital after having been thrown from a vehicle) that a head injury may have taken place.

b. Common symptoms found in the post-acute phase include physical problems with motor strength and coordination, post-traumatic headaches, pain, dizziness, fatigue, sleep disturbances, muscle spasms, seizures, and visual and vestibular impairments. In addition, patients may experience cognitive and personality changes, such as exhibiting new learning and memory deficits, impaired ability to attend and concentrate, diminished executive control, problems communicating, impaired judgment and insight, poor impulse control, difficulty controlling physical aggression, persistent irritability, mood lability, depression, and substance abuse. These impairments may make reintegration into civilian life and return to family and work problematic. Appropriate assessment and treatment can help with long-term outcomes.

c. Individuals presenting with symptoms such as these need to be evaluated for TBI. They may need referral to physical medicine and rehabilitation, mental health, clinical neuropsychology, or neurology services, or they may need to undergo brain imaging, such as by Magnetic Resonance Imaging (MRI). Clinicians need to discuss with families and caregivers the role TBI may play in causing the veteran's personality and cognitive changes. Long-term treatment is likely to require continuation of multidisciplinary care and case management. ***NOTE:*** *For more details about the diagnosis and treatment of TBI, see Veterans Health Initiative, Traumatic Brain Injury: A CME Program which can be found at: http://www.va.gov/vhi*

d. Extra caution needs to be exercised in pharmacological management, as patients with brain injury are more sensitive to medication side effects. Clinicians need to avoid agents likely to decrease or slow cognition or that may cause adverse side effects in this vulnerable population. Pharmacological treatment needs to be tailored to individuals with TBI. Before starting a medication, clinicians need to ensure new symptoms are not due to environmental stressors (e.g., caregiver conflict, sleep cycle disruption). Pharmacological treatment needs to start at low doses, with increased attention given to drug toxicity and drug interactions. Use of benzodiazepines, anticholinergics, or antidopaminergics need to be minimized as they may exacerbate cognitive dysfunction. Over the counter products containing caffeine or claiming to improve energy should be avoided, because their use has been linked to episodes of mania, aggression, or hypertensive crisis.

e. While TBI is a relatively common occurrence, evidence-based guidelines for diagnosis and treatment are limited. Current practice is based on expert opinion. Given the high rate of exposure to conditions that may cause TBI, it is important that primary care clinicians routinely screen for its occurrence. Patients with TBI remain at high risk for development of delayed symptoms. A comprehensive assessment and treatment plan needs to be pursued if such symptoms are present. To help develop such a plan, primary care providers need to consider referring patients likely to have TBI to physiatrists, clinical neuropsychologists, neurologists, or mental health professionals.

Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 1/26/06
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 1/26/06

Appendix 4: Department of the Army letter 40-01-1, 26 March 2001, *The Use of DD Form 2766 and DD Form 2766C*

DEPARTMENT OF THE ARMY
WASHINGTON, D.C. 20310

HQDA Ltr 40-01-1

DASG-HS **26 March 2001**

Expires 26 March 2003

SUBJECT: The Use of DD Form 2766 and DD Form 2766C

SEE DISTRIBUTION

1. Purpose. This letter prescribes two forms: DD Form 2766 (Adult Preventive and Chronic Care Flowsheet) and DD Form 2766C (Adult Preventive and Chronic Care Flowsheet--Continuation Sheet). The information in this letter will be incorporated into the next change to AR 40-66. When the change to AR 40-66 is published, it will supersede this letter.

2. Proponent and exception authority. The proponent of this letter is The Surgeon General. The Surgeon General has the authority to approve exceptions to this letter that are consistent with controlling law and regulation. The Surgeon General may delegate the approval authority, in writing, to a division chief within the proponent agency in the grade of colonel or the civilian equivalent.

3. References. Related publications and referenced forms are listed below.
a. AR 40-15, Medical Warning Tag and Emergency Medical Identification Symbol.
b. AR 40-66, Medical Record Administration.
c. AR 40-562/AFJI 48-110/BUMEDINST 6230.15/CG COMDTINST M6230.4E, Immunizations and Chemoprophylaxis.
d. DA Form 5571, Master Problem List.
e. DA Form 8007, Individual Medical History.
f. DA Label 162, Emergency Medical Identification Symbol.
g. HHS Form PHS 731, International Certificate of Vaccination.
h. SF 600, Medical Record--Chronological Record of Medical Care.
i. SF Form 601, Health Record--Immunization Record.

4. Explanation of abbreviations.
a. AFJI----------Air Force joint instruction
b. AR----------Army regulation
c. BUMEDINST--------Bureau of Medicine instruction
d. CG COMDTINST--Coast Guard Command instruction
e. DA----------Department of the Army

f. DD----------Department of Defense
g. DOD----------Department of Defense
h. HEAR----------Health Enrollment/Evaluation Assessment Review
i. HHS----------Health and Human Services
j. JCAHO----------Joint Committee on Accreditation for Health Care Organizations
k. MTF----------military treatment facility
l. PCM----------primary care manager
m. PHCA----------Preventive Health Care Application
n. SF----------standard form
o. SSN----------social security number
p. USPSTF----------U.S. Preventive Services Task Force

5. Use of the forms.

a. DD Form 2766 replaces the current Service-specific patient problem list for active duty and non-active duty adult beneficiaries in all Services.

(1) For the Army, DD Form 2766 replaces DA Form 5571 (Master Problem List) for active duty members and non-active duty adult beneficiaries. The DA Form 5571 will continue to be used in the Civilian Employee Medical Record. The DD Form 2766 replaces DA Form 8007 (Individual Medical History) and Standard Form (SF) 601 (Health Record--Immunization Record) for active duty members only.

(2) The DD Form 2766 consolidates the information from DA Form 5571, DA Form 8007, and SF 601, giving providers in the field more information to streamline care and to help assure that all standards of care are met. The form will provide continuity of care in the TRICARE system and during deployment.

(3) The DD Form 2766 is designed to track clinical preventive services as reported by the U.S. Preventive Services Task Force (USPSTF) in the Guide to Preventive Services, 2nd ed.; TRICARE Prime Benefit package; Advisory Committee on Immunization Practices; and AR 40-562/AFJI 48-110/BUMEDINST 6230.15/CG COMDTINST M6230.4E (covers immunization and deployment requirements). (Note: Sections are aligned for future use with the automated Preventive Health Care Application (PHCA) program to streamline data transference by nonmedical personnel.) Additional spaces are added in specific prevention areas to draw attention to high-risk areas and allow individualization of the form based on specific risk factors.

(4) The DD Form 2766 is intended as an interim measure until the PHCA is deployed to all sites and the form becomes automated.

b. The DD Form 2766 will replace DA Form 5571, DA Form 8007, and SF 601 for members of the U.S. Army Reserves and the Army National Guard when the next change to AR 40-66 is published. The Department of Defense (DOD) has mandated that this will occur not later than 1 April 1999.

c. The change to AR 40-66 will also prescribe the use of DD Form 2766 in place of DA Form 8007 for deployed civilians.

d. The DD Form 2766 is available in two constructions (folder and cut sheet).

(1) The folder construction will be used for active duty personnel. This construction is placed on the fasteners inside the existing DA Form 3444-series or DA Form 8005-series treatment folders. During deployments, DD Form 2766 will be removed from the treatment folder and accompany the individual to the field.

(2) The cut sheet construction will be used for non-active duty adult beneficiaries. This version consists of pages 1 and 2 only. Documentation of immunizations for these individuals will continue to be done on SF 601; if an automated immunization tracking system is in place, a printout from this system may be used instead of using an SF 601.

e. The DD Form 2766C may be used as a continuation sheet for either construction or for local requirements such as chemoprophylaxis. For example, if personnel run out of space for

deployment history in the six fields in block 11, data fields on DD Form 2766C can be changed to reflect the type of information required.

f. All information documented in the medical record is considered a part of the legal document. Superseded forms such as DA Form 5571 and DA Form 8007 will not be discarded from the medical record at any time.

(1) With the initiation of DD Form 2766, information from the current DA Form 5571 and DA Form 8007 will be transcribed onto DD Form 2766. Writing data in ink is required except in the "ordering exam" section, which is explained in the use of block 7 (para 7h below).

(2) If data are transcribed from the DA Form 5571 or the DA Form 8007, a line will be drawn through the information and the word Transcribed will be written along the line with the date, full name, rank, and Service-specific specialty code of the transcribing individual.

6. Source for the forms. Both the folder construction and the cut sheet construction are available through normal ordering channels.

7. Completion of the forms. Paragraphs i through m below apply only to the folder construction.

a. Identification data.

(1) Put an identification label in the "Patient Identification" block. Instead of this label, the patient's recording card may be used to stamp the form. Enter the individual's religion, race, and military occupational specialty or area of concentration along the bottom edge of this block.

(2) Legibly print the other requested identification data.

(3) For the folder construction, enter the social security number (SSN) in the hyphenated blocks along the top of the folder; enter the family member prefix in the circles to the left of these blocks.

b. Block 1--Allergies. Write the medication and other types of allergies within the area noted. Enter one of the following statements:

(1) Medical Warning Tag issued on (date); or

(2) Medical Warning Tag not issued.

c. Block 2--Chronic Illnesses. List chronic illnesses.

d. Block 3--Medications. In ink only, list the drug name and initiation date of significant or long-term medications. Do not include medications prescribed for acute illness or other short-term indications. Annotation of dosage, frequency, and purpose is optional and may be made in pencil to allow for adjustments. Line through long-term medications when discontinuing them.

e. Block 4--Hospitalizations/Surgeries. List hospitalizations and all surgeries, including dates.

f. Block 5--Counseling. The "Date," "Age," and "Topic" fields are intended to be filled in at the annual prevention assessment (for example, TRICARE Prime enrollment, or Preventive Health Assessment, or when the Service-specific health risk assessment (Health Enrollment/Evaluation Assessment Review (HEAR)) results are evaluated and the patient is counseled). Counseling is listed from general to specific. Place the letter associated with the type of counseling given in the corresponding "Topic" block (for example, "F" for Fitness). When all preventive health topics are addressed, write "all areas addressed" in the "Topic" block. Circle the letter that corresponds to the individual's high-risk profile. Extra blocks are provided for documentation of "outstanding" high risk preventive counseling accomplished at times other than the annual assessment (for example, alcohol abuse, mental health concerns, and so forth. This block is NOT to be used at every visit--document counseling initiatives on the current SF 600 (Medical Record--Chronological History of Medical Care) at every visit. The counseling block is not intended to take the place of quality counseling documentation on the SF 600 or assumed to be an official referral for further education at community-based services.

g. Block 6--Family History. In the larger block, fill in the family member's designation (for example, mother, father, and so forth) with the corresponding disease, using the key provided.

Specify the types of illness or disease. Document the age of the family member at the time of death if there is a correlation with the illness or disease process.

h. Block 7--Screening Exams. Exams are listed from general to specific. The form contains some elements of clinical preventive services and counseling that are mandated only for TRICARE Prime enrollees (for example, annual vision and dental exams). The availability of the full scope of the TRICARE preventive benefits package to other beneficiaries will be in accordance with regional TRICARE contract and local policy.

(1) Fill in the current year and age of the patient in blocks 7c and 7d and continue out for 6 years.

(2) Fill in the circles under the "Dates" field (block 7e) to denote the next time the test is due.

(3) Pencil in the date the exam is ordered.

(4) Use ink when the exam is completed and the results are written on the form.

(5) Use the proper key code or write in the actual results in the blocks.

(6) Update DD Form 2766 every time preventive care is ordered or performed, or results are returned.

i. Block 8–Occupational History/Risk. Check the appropriate box and list the exposure hazards as needed.

j. Block 9–Immunizations.

(1) Ink, sticker, rubber stamp, or automated documentation is required. The date and type of immunization must be recorded. Titers will be documented by the date and result, using the corresponding date square.

(2) Open data spaces are present to allow for flexibility of this form (for example, in case an injection or titer is required that is not presently listed).

(3) In accordance with the National Vaccine Injury Compensation Program, appropriate vaccine information must be recorded (per Service-specific regulatory guidance, AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E, and Health and Human Services (HHS) Form PHS 731 (International Certificate of Vaccination) for all personnel). The date square may be filled in by hand, stamp, sticker, or via automation in order to comply with national regulations. If documentation of the date and lot number is recorded in the medical record, it does not have to be duplicated on DD Form 2766. Attach the existing SF 601 to the fastener in the folder. The military treatment facilities (MTFs) may also use bar-coding to log in the lot information into their automated system.

(4) If an automated immunization tracking system printout is available, immunization information does not have to be transcribed by hand onto DD Form 2766. Instead, attach the automated printout to the fastener in the folder.

k. Block 10--Readiness. Enter the required information and the dates in the appropriate spaces.

(1) The optometry prescription will be written directly below the "Glasses/Gas Mask" description block. Changes of the prescription may be documented within the date block as needed. One of the blank fields may also be used for this information.

(2) If pregnancy is a possibility, use one of the blank spaces to write in the results of a pregnancy screen prior to deployment.

l. Block 11–Pre/Post Deployment History.

(1) Except for classified operations, document the deployment location as well as the completion date of the pre- and post-deployment evaluations. For classified operations, the record of deployment location will be maintained only in the personnel folder, along with any required pre- and post-deployment evaluations.

(2) The "Chart Audit" block (11c) is reserved for official inspections by the Joint Committee on Accreditation for Health Care Organizations (JCAHO) and for military inspections. It may also be used for the auditing of this form for the test survey. Place the audit date in the designated space.

m. Medical warning. Affix DA Label 162 (Emergency Medical Identification Symbol) to page 4 of DD Form 2766 for those individuals who have conditions that warrant the issuance of a medical warning tag in accordance with AR 40-15. This is necessary in case the DD Form 2766 is removed for deployment. Continue to place DA Label 162 on the outside of the DA Form 3444-series or DA Form 8005-series according to AR 40-15.

n. Chemoprophylaxis. Document the use of any chemoprophylactic agents on DD Form 2766C.

8. Disposition of the forms.

a. The DA Form 5571 and DA Form 8007 will remain with the medical record and be placed behind the current DD Form 2766 and the HEAR Primary Care Manager's (PCM) Report (when available). The DD Form 2766 will be located where the DA Form 5571 is currently located.

(1) When using the folder construction, the approved order of forms on the left side of the treatment folder is as follows: DD Form 2766, HEAR PCM Report, DA Form 5571, and DA Form 8007. The DD Form 2766C will be placed on the fastener on the right hand side of the DD Form 2766 folder.

(2) When using the cut sheet construction, the approved order of forms on the left side of the treatment folder is as follows: DD Form 2766, DD Form 2766C, HEAR PCM Report, DA Form 5571, and DA Form 8007.

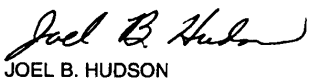
b. If an individual deploys, the DD Form 2766 will be photocopied prior to deployment and the copy will be kept in the medical record. The original DD Form 2766 will accompany the individual to the field. The DD Form 2766 will serve as the treatment folder while the individual is deployed; other forms such as SF 600 will be filed on the fastener inside the DD Form 2766.

c. The photocopy of the DD Form 2766 will be removed and shredded when the original is placed back into the record. Forms that had been filed inside the DD Form 2766 folder will be removed and filed in the regular treatment folder according to AR 40-66.

By Order of the Secretary of the Army:

ERIC K. SHINSEKI
General, United States Army
Chief of Staff

Official:



JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army

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U.S. ARMY MATERIEL COMMAND
U.S. ARMY TRAINING AND DOCTRINE COMMAND

Appendix 5: National Guard Bureau, NGB-ARS, Memorandum, 10 April 2007, *Medical and Dental Readiness*

DEPARTMENTS OF THE ARMY AND THE AIR FORCE
NATIONAL GUARD BUREAU
111 SOUTH GEORGE MASON DRIVE
ARLINGTON, VA 22204–1382

NGB–ARS

10 April 2007

MEMORANDUM FOR The Adjutants General of all States, Puerto Rico, the US Virgin Islands, Guam, and the Commanding General of the District of Columbia

SUBJECT: Medical and Dental Readiness

1. The Army National Guard (ARNG) has moved into a new era of mobilization and readiness that emphasizes home station preparation. This new era cannot accept policies and practices of an earlier era where much pre-deployment work was accomplished at mobilization sites.

2. Preparation for mobilization includes people, training, and equipment. Historically, the ARNG has focused primarily on the latter two issues. However, it is now more important to ensure that our people are prepared for mobilization in a timely and appropriate manner.

3. An ARNG unit recently being prepared for mobilization identified 309 Soldiers who required dental treatment in order to comply with mobilization standards. Funding for all 309 Soldiers was obtained and sent to the State. Unfortunately, 120 Soldiers failed to obtain the treatment required to render them deployable. The Soldiers instead reported to the mobilization site where each missed 48–72 hours of training while obtaining the necessary treatment services. Now that pre-deployment training time at the mobilization training site is significantly reduced, any missed training time because of medical or dental unreadiness threatens the validation of the unit. This failure to comply is directly related to leadership and accountability.

4. Collectively, the ARNG no-show rate for unit dental treatments was 24.4% for 2006, and the voucher no-show rate for individual dental treatment was 26%. This information is reported to senior Army leadership and the ARNG loses credibility in its ability to comply with new era requirements.

5. A fundamental, but unrecognized aspect of this problem is State loss of contact with some Soldiers after alert. Some cancel their cell phones or move back with their parents while awaiting movement. The contractor who provides medical and dental screening and treatment is then unable to contact the individuals. This situation cannot continue. I will instruct the contractor to contact the State directly when a Soldier cannot be found in anticipation that the State has current contact information.

NGB–ARS
SUBJECT: Medical and Dental Readiness

6. I anticipate that the Adjutant General will certify that Soldier medical and dental readiness has been accomplished, and I will validate that it has been accomplished to standard. We cannot perform these assessments unless we have appropriate documentation. Contemporary medical documentation is not paper; it is electronic and is incorporated into the ARNG medical systems. These systems, which are housed under the Medical Operational Data System (MODS) architecture, include: (a) the Health Readiness Record (HRR), (b) the Dental Classification System (DENCLASS), (c) the Medically Non-Deployable Tracking Module (MND–TM) and (d) the Medical Protection System (MEDPROS). You must have an adequate number of individuals (both professional and administrative) capable of data entry and interpretation so we may perform appropriate certification and validation.

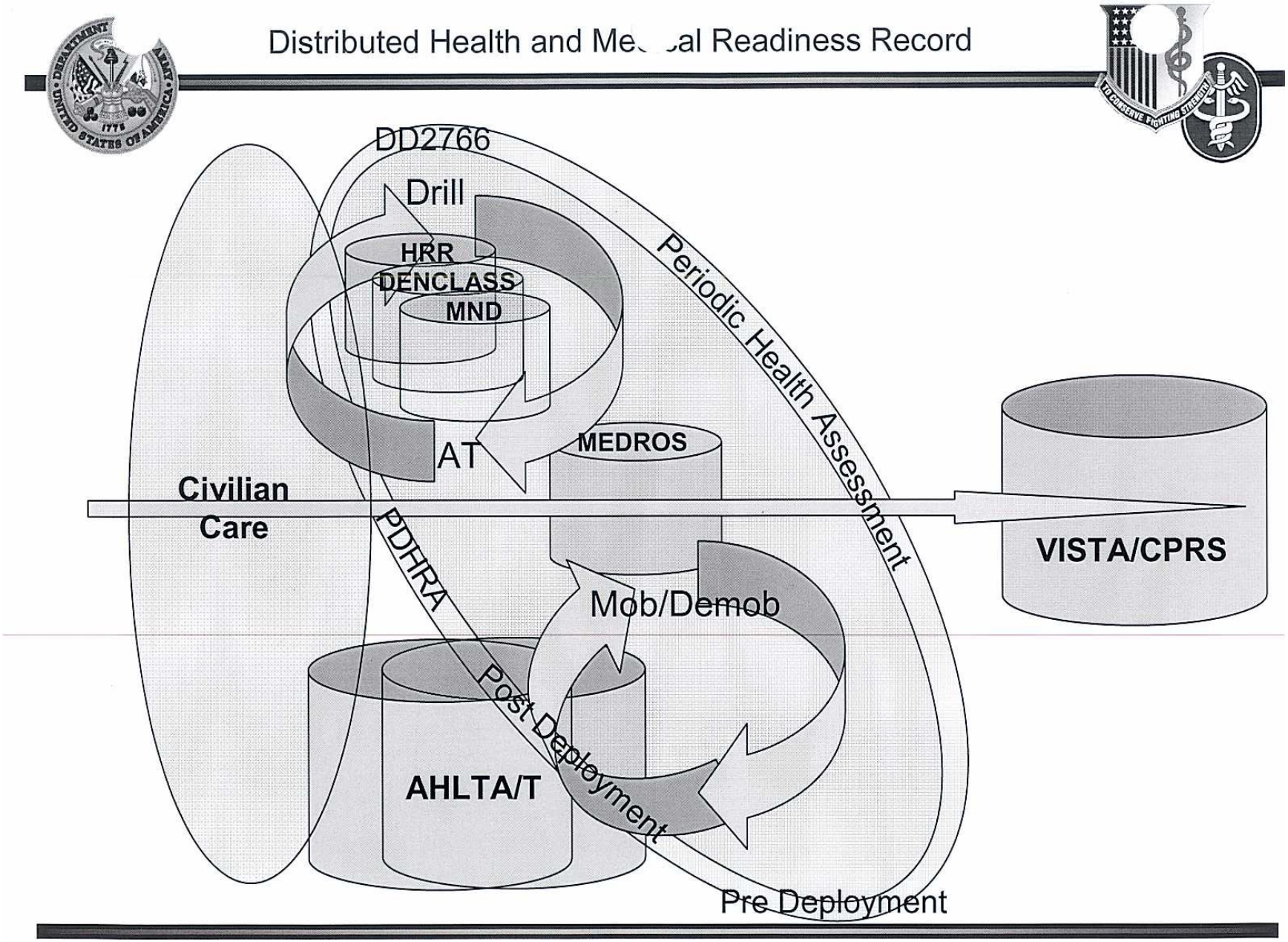
7. You must give individual Soldier medical and dental readiness your highest priority. We anticipate a wider alert window in which to cross-level personnel and conduct Periodic Health Assessments and dental screening examinations. We expect to have the funding and the time with which to accomplish appropriate treatment very soon. We have no excuses for not sending fully medically ready Soldiers to the mobilization sites to finish their training and deploy in a timely fashion.

8. The point of contact is Colonel Craig Urbauer, Chief Surgeon, at DSN 327–7141, 703–607–7141, or craig.urbauer@us.army.mil.

Clyde A. Vaughn

CLYDE A. VAUGHN
Lieutenant General, GS
Director, Army National Guard

CF:
Each State Surgeon
Each Deputy State Surgeon


Distributed Health and Me. .al Readiness Record
DD2766
Drill
HRR
DENCLASS
MND
AT
MEDROS
Civilian Care
Periodic Health Assessment
PDHRA
Mob/Demob
VISTA/CPRS
AHLTA/T
Post Deployment
Pre Deployment
MAJ Aaronson, DO/703.681.0490/jacob.aaronson@us.army.mil
UNCLASSIFIED
Slide 2 of 8
24 Feb 07

Health Readiness Records (HRR)

- Health Readiness Records (HRR)
  - Web-Based system interfacing with the Army, Navy, Marine Corps and Air Force imaging systems for the Official Military Personnel File (OMPF)
  - ARNG scanning all paper service medical records into web-based system
  - Records include all active NG members as of October 2006
  - VBA to discuss agreement to share information CAPRI through FHIE/BHIE
  - Imaging of all records is 71% complete - estimated completion date October 2007

Acronyms:
ARNG - Army National Guard
CAPRI - Compensation and Pension Records Interchange
FHIE - Federal Health Information Exchange
BHIE - Bi-Directional Health Information Exchange

Appendix 6: Public Law, Chapter 318, 123rd Maine State Legislature, An Act To Protect the Lives and Health of Members of the Maine National Guard

PLEASE NOTE: The Office of the Revisor of Statutes ***cannot*** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

Public Law

123rd Legislature

First Regular Session

Chapter 318
H.P. 1321 - L.D. 1889

An Act To Protect the Lives and Health of Members of the Maine National Guard

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, members of the Maine National Guard are being sent into military conflicts throughout the world; and

Whereas, the health and lives of Maine National Guard members are at constant risk; and

Whereas, it is essential to reduce these risks as soon as possible; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 5 MRSA §12004-G, sub-§26-F is enacted to read:

26-F.

Maine National Guard	Commission to Protect the Lives and Health of Members of the Maine National Guard	Legislative Per Diem and Expenses	37-B MRSA §532

Sec. 2. 22 MRSA §255-A is enacted to read:

§ 255-A. Commission to Protect the Lives and Health of Members of the Maine National Guard

The commissioner, through the Director of the Maine Center for Disease Control and Prevention, shall provide for assistance to the Commission to Protect the Lives and Health of Members of the Maine National Guard in order for the commission to achieve the purpose for

which it is created in Title 37-B, chapter 8-A. The Director of the Maine Center for Disease Control and Prevention and the Commissioner of Defense, Veterans and Emergency Management shall coordinate their resources, including staff assistance, to the commission and cooperate under the direction of the commission to provide a higher standard of preventative health care for members of the Maine National Guard.

Sec. 3. 37-B MRSA c. 8-A is enacted to read:

CHAPTER 8-A
Commission to Protect the Lives and Health of Members of the Maine National Guard

§ 531. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Center for disease control. "Center for disease control" means the Department of Health and Human Services, Maine Center for Disease Control and Prevention.

2. Commission. "Commission" means the Commission to Protect the Lives and Health of Members of the Maine National Guard established in section 532.

3. Maine National Guard. "Maine National Guard" includes the Maine Army National Guard and the Maine Air National Guard.

§ 532. Commission to Protect the Lives and Health of Members of the Maine National Guard; established

The Commission to Protect the Lives and Health of Members of the Maine National Guard is established.

1. Composition of commission. The commission consists of:

A. The Adjutant General, who serves ex officio;

B. The director of the center for disease control, who serves ex officio;

C. The Director of the Bureau of Maine Veterans' Services, who serves ex officio;

D. A physician licensed in the State with experience and knowledge of preventive care, appointed by the President of the Senate from a list provided by the Maine Medical Association or its successor organization;

E. A pharmacist licensed in the State, appointed by the Speaker of the House;

F. A retired Maine veteran who has served in a war zone, appointed by the Speaker of the House;

G. A family member of a deceased military person from the State who died from a noncombat cause while serving in a military capacity, appointed by the Governor;

H. A disabled Maine military person with a major noncombat disability suffered while serving in a military capacity, appointed by the President of the Senate; and

I. A psychologist licensed in the State, appointed by the Governor.

2. Advisory members. The Chief Medical Examiner within the Attorney General's office shall serve as a nonvoting advisory member. The Director of the Department of Veterans Affairs Medical at Togus Hospital or the director's designee may serve as a nonvoting advisory member.

3. Terms. Each commission member must be appointed to a 3-year term, except ex officio members, except that the terms of the initial members are staggered as follows.

A. The initial appointments made by the President of the Senate are for 3 years. The initial appointment of the retired veteran made by the Speaker of the House pursuant to subsection 1, paragraph F is for 2 years. The initial appointment of the family member of a deceased military person who died from a noncombat cause pursuant to subsection 1, paragraph G is for 2 years. The initial appointments of the psychologist and the pharmacist are for one year. All appointments after the initial appointments are for 3 years.

B. Ex officio members shall serve on the commission as long as they hold their offices. Other members serve until their replacements have been appointed. Members may be reappointed following the expirations of their terms.

4. Chair. The Governor shall appoint the chair of the commission from among its membership, who may not be an ex officio member of the commission.

5. Compensation. Members of the commission, except ex officio members, are paid a per diem and compensated for expenses at the same rates provided to Legislators under Title 5, chapter 379.

§ 533. Responsibilities of the commission

1. Responsibilities. The commission, with assistance from the department and the center for disease control, shall:

A. Review all the preventive health care treatment practices and protocols, including, but not limited to, physical and emotional screenings, vaccinations, electrocardiograms and physical examinations as they apply to members of the Maine National Guard in different age groups;

B. Review the vaccinations and other medications currently provided to members of the Maine National Guard, particularly those that produce allergic reactions and dangerous side effects, and compare the vaccinations and medications with those recommended by the National Institutes of Health, the United States Food and Drug Administration and other sources of standards of medical care;

C. Propose recommendations and seek approval from the Armed Forces of the United States for safer health care practices and protocols to be administered to members of the Maine National Guard;

D. Propose and seek approval from the Armed Forces of the United States for the Maine National Guard to retain a copy of the medical records of each member of the Maine National Guard who is sent to active duty;

E. Provide for the education of members of the Maine National Guard and other military personnel, especially medical staff, with respect to safer and more effective health care practices and protocols;

F. Assist the families of Maine National Guard members who died in military service from noncombat causes, including suicide, to obtain accurate and timely information in regard to the deaths of the Maine National Guard members;

G. Provide for the cooperation and coordination of assistance between the Maine National Guard and the center for disease control with respect to this chapter;

H. Work with the Bureau of Maine Veterans' Services to track the care of the physically and psychologically wounded Maine National Guard and Armed Forces service members from Maine within the health care systems of the United States Department of Defense and the United States Department of Veterans Affairs and serve as an advocate to ensure a high quality of care; and

I. Assist the Maine National Guard in ensuring appropriate demobilization procedures and follow-up for Maine National Guard members related to mental health issues, including, but not limited to, substance abuse and post-traumatic stress disorder.

2. Commission reports and recommendations. The commission shall report its findings and recommendations, including any necessary legislation, to the Governor and the joint standing committees of the Legislature having jurisdiction over legal and veterans affairs and health and human services matters.

A. The commission shall prepare a preliminary report for the Governor and Legislature regarding its efforts under this section by April 1, 2008.

B. The commission shall issue a complete report regarding its efforts under this section by December 15, 2008 and annually by December 15th thereafter.

§ 534. Meetings of the commission; public hearing

The commission shall meet at least 4 times a year, including at least one public hearing a year at which Maine National Guard members and their families, former Maine National Guard members and their families and members of the public may testify and present concerns and recommendations for the commission to consider.

§ 535. Assistance from state agencies

The Commissioner of Defense, Veterans and Emergency Management and the Commissioner of Health and Human Services through the center for disease control shall coordinate their resources and provide assistance, including staff assistance, research, reports and other assistance, to the commission in order to provide a higher standard of preventive care to members of the Maine National Guard.

Sec. 4. Purpose. The intent of this Act is to provide higher and safer standards for preventative medical practices and health screenings administered to members of the Maine National Guard than currently exist and to encourage the federal military forces to adopt these higher standards. It is also the intent of this Act to prevent future noncombat deaths and injuries of military personnel by creating the Commission to Protect the Lives and Health of Members of the Maine National Guard and by directing the Maine National Guard and the Maine Center for Disease Control and Prevention to take such action as necessary to accomplish this purpose including coordination and cooperation between these 2 agencies.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

Effective June 18, 2007.

Appendix 7: Article – Problems With Military Vaccines, Meryl Nass, MD

Problems with Military Vaccines
Meryl Nass, MD

Although biological warfare is considered a military threat, achieving mass casualties is extremely difficult. Historically, the target has been civilians, not troops. Nonetheless, the Defense Department has undertaken to vaccinate all deploying soldiers to Central Command with anthrax and smallpox vaccines: approximately 1.8 million soldiers have received each in the past ten years.

In retrospect, the current administration used the threat of chemical and biological warfare to buttress a preemptive strike on Iraq in 2003. Initiating smallpox vaccinations for soldiers and civilians may have had more to do with public relations than public health. The civilian program stopped after 40,000 inoculations, due to cardiac complications.

Despite this, the mandatory military smallpox vaccination program has never slowed down. According to the CDC Advisory Committee for Immunization Practices, such vaccination programs require a risk-benefit analysis, which was never performed. The Institute of Medicine's analysis of the smallpox program noted, "The combination of known vaccine-related problems and an immeasurable disease threat was deeply problematic."

The smallpox vaccine caused myocarditis in one of every 145 people who received it in a clinical trial, leading to a black box warning in the label. However, the warning fell on deaf ears, since the vaccine remained a requirement for deployment.

Recently, a newer smallpox vaccine, derived from the old vaccine, was licensed. The government announced that stocks of the old vaccine would be destroyed, and the new vaccine would be given to soldiers. But is there really a difference? The new vaccine is said to cause myocarditis in one in 175 recipients.

The anthrax vaccine story is similar: the General Accounting Office reported to Congress in both 1999 and 2006 that the long-term safety of the vaccine is unknown. Crucial data and research remain buried.

Although civilians injured by smallpox vaccine can seek compensation from a government fund, soldiers are barred by the Feres Doctrine from compensation, and their only recourse in the event of illness is the healthcare system of the military and Veterans Administration. Unfortunately, vaccine-induced illnesses generally respond poorly to treatment.

In the absence of both demonstrable threat and effectiveness against biological weapons, these pork barrel vaccine programs exact much too high a price from our service-members and our treasury. It is time to end the politicization of military public health.

Appendix 8: Article – Self-Reported Mental Health Status And Needs Of Iraq War Veterans In The Maine Army National Guard, Elizabeth Wheeler, Ph.D.

Self-reported Mental Health Status and Needs of Iraq War Veterans in the Maine Army National Guard

Elizabeth Wheeler, Ph.D.

The war in Iraq has raised important concerns regarding mental health problems suffered by Iraq veterans and the treatment resources that will be required to address the needs of these veterans. Almost 90% of the Maine Army National Guard has been deployed to Iraq, and anecdotal reports have suggested that some Iraq veterans are experiencing significant problems in relationships with family and friends, problems at work, and difficulty in day-to-day functioning.

The research project reported below was developed and conducted by Dr. Elizabeth Wheeler, in collaboration with Major General John W. Libby and his chief medical officer, Colonel Kimberly Boothby-Ballantyne. The Survey Research Center at the Muskie School of Public Service at the University of Southern Maine provided consultation on research design and survey development, and provided data entry and analysis. The project was funded by the Community Counseling Center in Portland, Maine, which contracted Dr. Wheeler to investigate the needs of returning veterans.

In 2006, surveys were completed anonymously by all National Guard members in Maine unless they were deployed or engaged in other Guard-related activities. Surveys were administered at weekend drills in Augusta (two units), Bangor (five units), Belfast, Caribou, Gardiner, Houlton, Lewiston, Norway, Portland, Presque Isle, Sanford, Skowhegan, Waterville, and Westbrook. A total of 532 Guard members were surveyed, of which 292 were Iraq veterans. Most of the Iraq veterans had returned a year before they completed the survey.

Other sites of deployment included Hurricane Katrina, the Persian Gulf, Bosnia, Afghanistan, Guantanamo Bay, Viet Nam, and Kosovo. There were not sufficient numbers of veterans from any of these other sites to analyze their data separately or draw conclusions about their mental health issues. When analyzed as a group, National Guard members who had been deployed to sites other than Iraq generally reported less severe levels of disturbance than Iraq veterans but greater levels of combat exposure, life stress, posttraumatic stress symptoms and problems with alcohol than Guard members who had not been deployed at all. The results for Iraq veterans are reported below.

Guard members' experiences in the war zone

Over three-quarters of Iraq veterans reported that they had been exposed to life threatening experiences such as being shot at, going on combat patrol, or other situations in which they were in danger of being injured or killed. Similar numbers also had seen dead bodies and/or had known someone who was killed or seriously injured. The severity of these traumatic experiences is highly significant, and is similar to the reported severity of combat trauma among members of the Army deployed to Iraq.

Post traumatic stress reactions

"Hyperarousal" symptoms were reported by well over one third of Iraq veterans and were the most frequently reported symptoms. These include feeling jumpy or easily startled, feeling keyed up and irritable, having angry outbursts, having difficulty with sleep and concentration, and generally having difficulty relaxing and "letting their guard down". "Re-experiencing" symptoms, reported by approximately one quarter of Iraq veterans, include experiences such as flashbacks (when upsetting images of the war-zone flash into their mind, making it difficult to think or concentrate), nightmares, and feeling very upset and having physical reactions (such as heart pounding, trouble breathing) when something reminds them of a war zone experience. Feeling emotionally numb was reported by roughly one third of Iraq veterans. This includes feeling unable to have loving feelings for those close to them, feeling distant and cut off from other people, and losing interest in activities they used to enjoy.

A diagnosis of PTSD requires that all three of the above types of reactions be strongly present. Our findings indicate that at least 13% of Iraq veterans in Maine would qualify for a diagnosis of PTSD. This is similar to published reports of PTSD for members of the Army and Marines who served in Iraq.

One quarter of Iraq veterans also reported that they drink too much alcohol, which is a common way many try to avoid upsetting traumatic stress reactions. Unfortunately, alcohol abuse adds to the problems caused by PTSD by interfering with relationships, job performance, and other key areas of functioning.

Depression

Significant symptoms of depression were reported by over one in four Iraq veterans. Symptoms included feeling tired and having little energy, not being interested in pleasurable activities, poor concentration, and changes in appetite and sleep patterns. Depression sometimes causes people to think about hurting or killing themselves, and one in ten Iraq veterans acknowledged such thoughts. (It should be noted that among Guard members who had not been deployed, one in fourteen reported similar thoughts, which is only slightly higher than the rate for the general population.)

Effects on relationships, work, and personal life

Iraq veterans face a variety of challenges in readjusting to life with their families and communities. Our research indicates that a year after returning from Iraq, veterans are having significant problems in relationships with partners and children. Many veterans reported that they experienced significant stress in these primary relationships. In addition to having more interpersonal conflict, many Iraq veterans indicated that they felt disconnected or detached from loved ones and civilian friends. They frequently reported not having fun in life and not being able to relax. Combat stress reactions, such as problems with anger or concentration, having trouble sleeping, or problems relating to people, can also make returning to work very difficult, and large numbers of veterans reported significant stress at work. Significant financial stress was also frequently reported, as were physical health problems.

Interest in mental health treatment

Very few Iraq veterans had sought help for readjustment problems, although roughly one third of veterans said they were interested in receiving help. Iraq veterans said the kinds of services they

were most interested in were support groups with other veterans, individual counseling, education regarding war zone stress and the readjustment process, anger management, and couples' counseling. Iraq veterans also said they thought family members would be interested in services such as couples' counseling, support groups for family members, education regarding readjustment issues, and individual counseling.

CONCLUSIONS

This study provides the first systematic assessment of members of the Maine National Guard who were deployed to the Iraq war. Our findings indicate that large numbers of Iraq veterans report mental health problems as well as significant stress in relationships with family and friends and problems at work Members of the Guard deployed to other sites also report significant but less severe readjustment issues, consistent with their lower level of combat exposure. Our findings establish the need to address the readjustment concerns of Iraq veterans.

Fortunately, effective, evidence-based treatments exist and early treatment can prevent worse problems from developing. Needed services include specialized educational support and therapy groups for veterans and their partners, individual and couples therapy, as well as specialized evidence-based trauma treatments for individuals experiencing significant posttraumatic stress reactions. To meet the needs of our Maine National Guard citizen soldiers as they return to their families, communities and workplaces, it is extremely important to have a strong network of services available to them in their communities.

Appendix 9: Spreadsheet To Track Identified Types of Illnesses Experienced By Persian Gulf and Global War On Terror Veterans

ID #	Last Name	First	MI	Service	Unit	CO	Dates of Service			Country	Dates of Service			Country
1	Doe	John	J	MCR	25th Reg	25-Jan	Dec-90	to	Sep-91	Iraq		to		

ID #	Unit	Country	Dates	Anthrax	Pyridostigmine	Exposed Oil Fires	Exposed D-U	Epoosed Khamisiyah	COPD	Pulmonary Emphysema	Bronchial Asthma
1	1/25 MC	Iraq	90-91	y	y	y	y		n	n	n

Appendix 10: Maine Veterans Medical Survey of Persian Gulf Veterans and Health Questionnaire

John W. Libby
Major General
Commissioner
207-626-4271

Peter W. Ogden
Director
207-626-4464

Department of Defense, Veterans and Emergency Management
Maine Veterans' Services
117 State House Station, Augusta, ME 04333-0117
Tel.: 207-626-4464

December 1, 2008

Office of the Director

SUBJECT: MAINE VETERANS MEDICAL SURVEY OF PERSIAN GULF VETERANS

Dear Veteran:

In an effort to continue to provide maximum service to Maine veterans and their families, the State of Maine, Bureau of Maine Veterans Services is conducting a medical survey of veterans who have served in the Persian Gulf (1990 to present) during Operation Desert Shield, Operation Desert Storm, Operation Enduring Freedom and Operation Iraqi Freedom. The Bureau, in keeping with its tradition of strong, competent veteran's advocacy, is asking that you participate in this important survey.

The answers to all questions in this survey are voluntary and completely confidential. At no time will your name or other identifier be linked to the information in the questionnaire or with the results of the study.

As a veteran, you have already made a major personal commitment to your country. Now take some time to do something for yourself, your fellow veterans and your families by working together to answer some of the questions that face us now. If you are the surviving spouse of a veteran who served in the Persian Gulf since 1990 we ask that you complete this form if possible, according to the best of your ability.

We cannot accomplish this task without your help and cooperation. We ask for your help and remind you that you, as the veteran or the veteran's family, have the right to demand answers to questions that affect your lives.

Thank you for your help and attention to this important matter. Should you have any questions or comments please call me at (207) 626-4464.

Sincerely yours,

Peter W. Ogden
Director

PERSIAN GULF/ OIF/ OEF/ GWOT
Health Questionnaire

Veteran Name: _____
(Last) (First) (M.I.)

Veteran Address: _____

_____

Veteran Telephone: ( )_____

Next of Kin: _____
(Relationship)

Telephone: ( )_____

Served in: __ Kuwait __ Iraq __ Afghanistan __ Other _____

Dates of service: _____ to _____; _____ to _____;

_____ to _____; _____ to _____

Status: __ Active Duty; __ National Guard; __ Reservist; __ Other _____

___ Army ___ Marines ___ Navy ___ Air Force ___ Coast Guard

Military Unit Assigned to: _____

YES NO

___ ___ I have been examined for Gulf War Syndrome/ Petro-Chemical Poisoning at a VA Facility. ____ Togus, ME; ___ Other _____

___ ___ I have field a claim with the VA for service-connected illness in regards to to the Gulf War Syndrome.

___ ___ I have filed a claim with the VA for service-connected injuries in regards to my service in the Gulf.

Please check appropriate boxes:

YES NO

___ ___ I was given Anthrax in ___ pill form or by ___ Injection;

___ ___ I was give Pyridostigmine in ___ pill form or by ___ injection;

___ ___ I was exposed to the oil fires and CO^2

___ ___ I was exposed to depleted uranium

___ ___ I was exposed to chemicals from Khamisiyah

I suffer from:

___ ___ COPD (Chronic obstructive pulmonary disease)

___ ___ pulmonary emphysema;

___ ___ bronchial asthma;

___ ___ lung cancer;

___ ___ gastric internal problems;

___ ___ flu-like symptoms;

___ ___ hair loss;

___ ___ loose teeth;

___ ___ sore gums;

___ ___ sore muscles;

___ ___ chronic bronchitis;

___ ___ joint pain;

___ ___ chronic fatigue;

___ ___ I am being treated by my private physician for symptoms relating to my service in the Gulf.

Additional Comments: _____
_____
_____

Appendix 11: Testimony from James R. Bradshaw

-----Original Message-----
From: Embarq Customer [mailto:jrbradshaw@embarqmail.com]
Sent: Sunday, September 21, 2008 2:14 PM
To: Ogden, Peter W
Cc: acorn444@yahoo.com
Subject: Middle East Immunizations

Sir,

I became aware of Captain Patrick Damon's death of unexplained causes in Afghanistan through a newspaper article (Dallas Morning News/Sunday May 20, 2007). I've corresponded with Barbara Damon-Day and she led me to your Hearings.

I was employed/deployed to Kuwait/Iraq by Kellog Brown & Root as a Quality Control Inspector in April 2004. I resigned in May 2005. In that thirteen months, my health fell apart. So far, I've had surgery to repair blood vessels in my left leg, one stent in iliac artery, and four stents at my heart. I have to take 75mg Plavix, 10mg Crestor, and 325mg aspirin daily. My blood is thinner than jet fuel. I have little energy, tire easily, little to no sex, and generally feel like crap. I asked my Primary Care Physician: John O'Donnell MD

3201 South Loop 256
Palestine, TX 75801

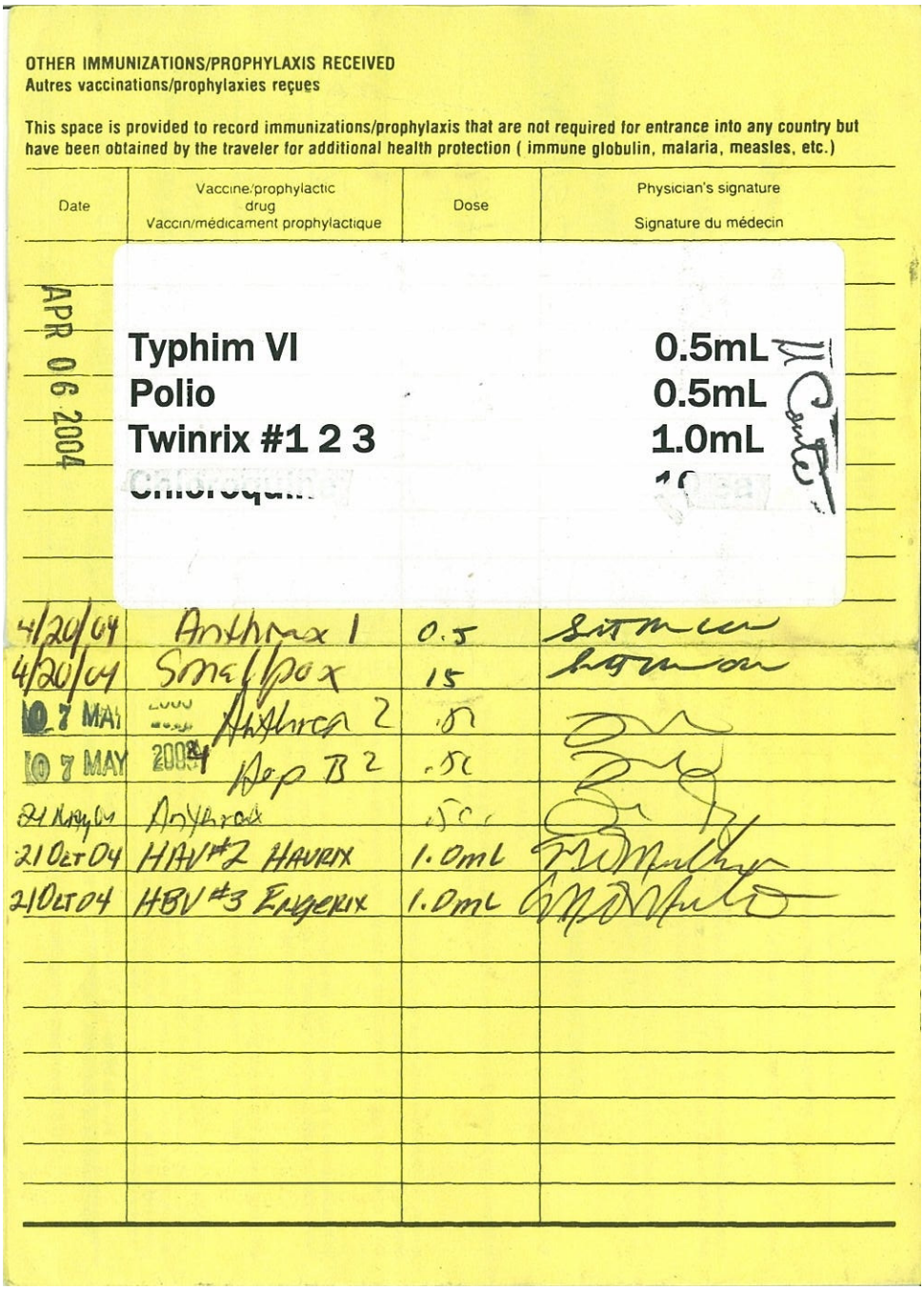
903.723.8800
if any evidence or research exists linking Middle East Immunizations to deteriorating blood vessels? He told me later, No? Well, something happened to me, over there!! Employment was based on mandatory training and immunizations (International Certificate of Vaccination attached).
I received several shots in Houston, TX and the remainder at Camp Arifjan, Kuwait. After injections in Houston, I was queasy, disorientated, and listless, with cold chills followed by heavy sweating, followed by cold chills, followed by heavy sweating..... The next morning, every joint and muscle in my body ached. I felt like I had a terrible hangover, been in a car wreck, and got beat up. The injections I received at Camp Arifjan resulted in similar symptoms, along with vomiting.

Anyway, Mr. Ogden, I told you all this to tell you something affected my health over there. If you think I can help prevent the death of another Hero, such as Captain Damon, please call me out.

Sincerely,

James R. Bradshaw
110 Stephanie Drive
Palestine, TX 75801
903.723.0194
jrbradshaw@embarqmail.com

Appendix 12: Pocket Sized Military Immunization Record



OTHER IMMUNIZATIONS/PROPHYLAXIS RECEIVED
Autres vaccinations/prophylaxies reçues

This space is provided to record immunizations/prophylaxis that are not required for entrance into any country but have been obtained by the traveler for additional health protection (immune globulin, malaria, measles, etc.)

Date	Vaccine/prophylactic drug Vaccin/médicament prophylactique	Dose	Physician's signature Signature du médecin
APR 06 2004	Typhim VI	0.5mL	
	Polio	0.5mL	
	Twinrix #1 2 3	1.0mL	
	Chloroquin...	1(	
4/20/04	Anthrax 1	0.5	
4/20/04	Small pox	15	
07 MAY	Anthrax 2	.5	
07 MAY 2004	Hep B 2	.5	
24 May 04	Anthrax	.5	
21 OCT 04	HAV #2 HAVRIX	1.0mL	
21 OCT 04	HBV #3 ENGERIX	1.0mL	

Appendix 13: Questions from the Commission – Answers from TOGUS VA

As the Commission to Protect the Lives and Health of Members of the Maine National Guard begins to look at existing resources for Maine's soldiers, we would benefit enormously from better understanding the services provided at the VA facility at Togus.

Here are the questions Commission members would like responses to:

1. Are all medical records at Togus electronic? If not, which are/aren't?

Yes at Togus, the Community-Based Outpatient Clinics and the two mental health clinics. Although Veterans Readjustment Counseling Centers (Vet Centers) have access to the VA Computerized Patient Record System (CPRS), they do not keep their records in CPRS and currently utilize paper records.

2. Are the diagnostic codes used at Togus the same as civilian diagnostic codes? If not, how do they differ? Are there additional codes?

They are the same ICD-9 (International Classification of Diseases) codes used by all medical organizations. There are no additional or VA specific diagnostic codes.

3. Are there specific codes for disability ratings? For what disabilities? How do the ratings work?

There are VA specific codes for all VA recognized service-connected disabilities. Disability ratings are determined by a very experienced rating specialist who reviews the findings of the rating exams and assigns a disability rating for each claimed disability. These ratings are in increments of ten (10%, 20% 30%, etc.) Then the overall disability rating is determined by a VA scale that includes all the disabilities. The percentages when added up do not necessarily equal the percentages from straight addition because some might be considered together.

4. Within those diagnostic and disability codes, how are causes identified? For example with PTSD: childhood sexual abuse vs. combat related? Is severity (of PTSD et al) rated and how?

Causes are determined by the veteran providing the necessary background medical and/or service record information and based on a rating exam. The examining provider then provides the severity of the claimed medical condition to the rating specialist who determines if the condition is a service-connected condition or not. Severity of PTSD is determined based upon the rating exam conducted by a mental health provider who provides results of the exam to the rating specialist. Severity is determined by how much the condition impacts a veteran's ability to function in their daily life.

5. How many veterans have ever sought VA services in Maine? How many veterans have never sought VA services in Maine? How many are current, active patients in numbers and percentages? Please provide these data by war and by age.

VA became the Veterans Administration in 1930 and Togus does not have records going back that far. Togus only has records dating back to 1988 and the total number of unique veterans receiving some type of medical service since then is 126,040. These numbers do not necessarily include those also receiving services from the Veterans Benefits Administration (VBA) or Readjustment Counseling Centers (Vet Centers). Togus cannot determine the number of veterans that have never sought VA services.

Togus does not track veterans receiving healthcare by war/conflict. In FY2007, approximately 38,000 Maine veterans received VA healthcare services with percentages by age provided below:

<25 1%
25-34 2%
35-44 5%
45-54 11%
55-64 31%
65-74 22%
75-84 22%
85+ 6%

6. Could you describe the structure of all Federal VA service facilities throughout Maine and what each provides? What is the breakdown of numbers of veterans, by services received, at each of these facilities?

Togus VA Medical Center in Augusta is a full-service medical center providing primary care, specialty care, inpatient medical/surgical beds, an intensive care unit, laboratory, emergency department and a wide range of mental health services. It also has a pharmacy, laboratory and nursing home care units. Approximately 19,000 veterans receive their primary care at Togus and Togus is the site for all specialty care.

There are 6 community-based outpatient clinics (CBOCs) located throughout Maine which provide primary care, mental health and lab services for an additional 19,000 veterans. There is a part-time access point in Fort Kent that is a satellite of the Caribou CBOC. Another part-time access point in Houlton will be operational by June 2008. Vet Centers are a VA special program that provides readjustment counseling for combat veterans.

Location	Veterans Served
TogusVAMC	19,000
Bangor CBOC	5,400
Calais CBOC	1,400
Caribou CBOC	3,300
Lincoln CBOC	850
Rumford CBOC	2,400
Saco CBOC	5,700
Bangor Mental Health Clinic	1,100
Portland Mental Health Clinic	800
Bangor Vet Center	400
Caribou Vet Center	135

Lewiston Vet Center	235
Portland Vet Center	250
Springvale Vet Center	225

7. What specific PTSD screening and psychotherapy are offered at Togus and around the state? How many have been screened for PTSD? How many were found positive and of these how many are receiving services? How many received services and are now discharged?

VA has a nation-wide clinical reminder protocol as part of the healthcare program. When veterans present, they are asked a series of standardized questions and, based upon the responses, they may receive a more in-depth screening. These protocols are followed at Togus VAMC as well as all the VA clinics located throughout Maine and the country. Togus, 5 CBOCs and 2 mental health clinics provide on-site mental health services consisting of individual and group counseling. Togus has a one week intensive outpatient PTSD program designed to provide the necessary services to OEF/OIF veterans who have jobs and/or don't want their employers to know they are participating in a mental health program. They can also receive some PTSD services at the 5 Vet Centers in Maine which also have off-site outreach sites throughout the state. Out of 2,050 OEF/OIF veterans receiving VA care, 11% of OEF/OIF Maine veterans presenting have some level of PTSD. All veterans with PTSD have access to PTSD treatment/counseling whenever required.

8. How many Maine veterans are anticipated to have PTSD from the current wars?

The unknown factor is how many veterans will enroll and seek services at a later date.

9. What kinds of outreach are in place to access veterans who may be suffering from PTSD or TBI? What other VA outreach programs exist for Maine Veterans?

VA staff (VHA, VBA and Vet Center) meet returning National Guard (NG) soldiers the day of their return to Maine and are given briefings and provided the opportunity to enroll for VA healthcare and/or file a disability claim for VA Benefits. Additionally, the Maine NG requires soldiers to meet that day for a minimum of 15-20 minutes with a Vet Center or Togus mental health counselor. DoD mandates a Post-Deployment Health Reassessment (PDHRA) for all service members returning from Iraq or Afghanistan 3-4 months after they return to their home base. During a PDHRA, DoD medical contractors conduct an evaluation of service members based on their responses to a standardized evaluation (which includes mental health and TBI) and then refers them to VA or other health care. During a PDHRA, Vet Center and/or VA counselors again have the opportunity to meet with the service members. It should be noted that only the Maine NG requires the meeting with the VA and/or Vet Center counselors and each Reserve unit has its own requirements. VA also meets with Maine NG soldiers during a Military Adjustment Program (Maine NG initiative) which is typically 5-6 months after their return to Maine. Maine VA staff also regularly attend and make themselves available at any Welcome Home or other events in support of OEF/OIF veterans.

10. How many veterans have been screened for TBI? How many are receiving specific services for TBI? How many have received services and are now discharged?

Togus has screened 828 for TBI with 177 positive screens. Of 177 positive screens, 39 received positive diagnosis of "post-concussive syndrome (310.2)' following evaluation by Physiatry and/or Neuropsychology. One OIF (combat related) veteran was in the Togus long-term nursing home unit (NHCU) and has been discharged and another (noncombat related) veteran was on the same Tog us NHCU but is now receiving services at a non-VA facility.

11. What types of benefits can members of the Maine National Guard receive for Mental Health services (including number of sessions, how long eligible for these benefits, what Mental Health services are available to family members of MNG, how are they made aware of these and how many family members received services)?

Members of the Maine National Guard or reserve units activated under Title 10 and who served in Iraq and/or Afghanistan and completed their tours are eligible for enrollment for VA healthcare. As such, they are entitled to 5 years of free VA healthcare for any medical condition which could be reasonable associated with their tour in Iraq or Afghanistan. Depending on income, they might incur a modest co-pay for anything not associated with their OEF/OIF service. As such, they are entitled to VA mental health care via Togus VAMC and/or its outpatient primary care/mental health clinics or the Vet Centers. Once enrolled, they are continuously eligible for these services and there is no limit on the number of appointments, etc. Mental health services are not specifically provided to family members although they are sometimes included as part of the veteran's treatment plan. The veteran would be advised by the VA mental health provider of the feasibility of a family member(s) participating in the treatment program based on if it would benefit the veteran himself/herself. Vet Centers have a somewhat more liberal policy regarding mental health coverage for families of combat veterans and they provide bereavement counseling as required for families of OEF/OIF veterans who died or were killed in Iraq or Afghanistan. Togus does not track the number of family members participating in the veteran treatment programs.

12. How many Gulf War and Gulf Era Veterans are there in Maine? How many have sought services at the VA? How many have been diagnosed with Gulf War Syndrome or other diagnoses related to this condition? How many have received services and been discharged?

The original Desert Storm/Gulf War was never completely concluded for record purposes such that even service members in the current conflict in Iraq are considered Gulf War/Era veterans. There are approximately 19,000 Gulf War/Era veterans including approximately 8,000 from OEF/OIF. Togus VA does not track veterans receiving VA healthcare as to a particular conflict or time of peace. There is not a clinical diagnosis of Gulf War Syndrome (GWS) but veterans are seen for illnesses or medical conditions that may be associated from their service in the Gulf. Beginning in 1992 until the present, 938 veterans enrolled in the Togus Gulf War Registry. These veterans receive full lab workups and a general exam with particular emphasis on any issue the veteran notes. Due to the nature of the various symptoms associated with Gulf War Syndrome, these veterans receive pulmonary function tests and/or sleep apnea testing as necessary.

13. How many Iraq and Afghanistan War veterans are there in Maine? How many are/have been patients in VA system? What are the categories of complaints for this group, by country?

It is estimated there could be up to 8,000 OEF/OIF veterans in Maine. It is hard to be more accurate since many are veterans who separate from active duty in other states and can only be counted if they have their DD-214s sent to Maine. It is easier to determine accurate numbers for the Maine National Guard and reserve units in Maine. More than 2,450 OEF/OIF veterans have enrolled for VA healthcare in Maine and approximately 2,050 are actively using some type of VA healthcare services. The major medical services requested are for primary care and/or mental health and are essentially the same for either country.

14. What actions have Togus and the VA taken to date to prevent suicides in the veteran population? What additional actions are planned for in the future?

To further expand VA suicide prevention efforts nation-wide, VA instituted a 24/7 suicide prevention call center in September 2007. The number is 1 -800-273-TALK. Calls are received and triaged by VA mental health professionals to immediately address the potential problems and then follow-up with the appropriate VA mental health services in the veteran's service area. Additionally, each VA medical center has a full-time Suicide Prevention Coordinator (SPC) to interact directly with veterans and/or veteran family members in crisis. The SPC, a psychologist, also provides training to VA staff to make them aware of suicidal behaviors and to enhance their sensitivity to veterans in crisis with whom they are in contact. In addition, they closely track any veterans identified as "high risk" for suicide based upon the clinical assessment.

15. Recently, the first and only Agent Orange Clinic was opened in Wichita Falls, Texas, "to test, diagnose and treat for Agent Orange Diseases". When and where will an Agent Orange Clinic be opened closer to Maine veterans?

The clinic addressed above is a single provider private clinic operating as part of a larger neurology practice. Togus is unaware of any private Agent Orange clinics opening in Maine or New England. Togus VAMC has the capacity, experience and capability to treat veterans with the various presumptive illnesses/diseases associated with Agent Orange.

16. What is currently available to test, diagnose and treat for Agent Orange Diseases at Togus? How many are being served who are suffering from Agent Orange related diseases? How many have received services and been discharged? How many have died from Agent Orange related diseases?

There is not a clinical diagnosis of Agent Orange (AO) but veterans are seen for illnesses or medical conditions that may be associated from their service in Vietnam. Beginning in 1981 until the present, 5,135 veterans enrolled in the Togus AO Registry. These veterans receive full lab workups and a general exam with particular emphasis on any issue the veteran notes. Based on there not being a clinical diagnosis of AO, Togus does not track deaths associated with AO.

17. Has Togus instituted the "Home Tele-Health Program for Diabetes and Heart Failure"? If so, when? How many are connected and receiving this form of service? If not, what is the date this program will be available for Maine veterans?

Togus instituted the "Home Tele-Health Program for Diabetes and Heart Failure" in

2004. Currently there are 107 veterans enrolled in that program (which also includes Hypertension) as well as an additional 45 veterans enrolled in the Home Tele-Mental Health Program. Of note, some of the enrolled veterans have multiple conditions that are being covered by these tele-health programs.

Appendix 14: Background Information on Recommendations

Background Information on Recommendations from the Commission to Protect the Lives and Health of Members of the Maine National Guard:

Federal Level:

Urgent need to establish interoperable (non-*pdf*) electronic medical records, seamlessly and rapidly transferable between DoD and VA

Background:

Military medical records should transfer immediately and accurately to VA when soldiers leave active duty. This would allow VA to provide improved treatment, and better inform VA of the types of medical problems being seen by military medical providers following deployments. It would also provide VA with needed information on soldiers' environmental and vaccine exposures.

But despite being tasked to produce such a medical record by the President in 1998,[1] a 2007 GAO report[2] stated the following:

> *DOD and VA have been engaged in multiple efforts to share electronic medical information, which is important in helping to ensure that active-duty military personnel and veterans receive high-quality health care. These include efforts focused on the long-term vision of a single "comprehensive, lifelong medical record for each service member" that would allow a seamless transition between the two departments, as well as more short-term efforts to meet immediate needs to exchange health information, including responding to current military crises.*

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[1] The report states that a Directive issued by President Clinton in 1998 required VA and DOD to develop a "computer-based patient record system that will accurately and efficiently exchange information."

[2] GAO Testimony. INFORMATION TECHNOLOGY: VA and DOD Are Making Progress in Sharing Medical Information, but Remain Far from Having Comprehensive Electronic Medical Records. Statement of Valerie C. Melvin, Director Human Capital and Management Information Systems Issues. July 18, 2007. GAO-07-1108T

But the same GAO report noted only limited progress:

> *Through all these efforts, VA and DOD are achieving exchanges of health information. However, these exchanges are as yet limited, and it is not clear how they are to be integrated into an overall strategy toward achieving the departments' long-term goal of comprehensive, seamless exchange of health information. Consequently, it remains essential for the departments to develop a comprehensive project plan to guide their efforts to completion, in line with our earlier recommendations.*

Interventions:

a) Congress should make one office in VA and DOD, such as an Undersecretary for Information Technology, accountable for jointly developing and implementing a comprehensive plan to achieve a seamless, searchable DOD-VA electronic medical record, and require frequent progress reports on this initiative.

b) On an interim basis, mlitary medical records should be required to transfer to VA within one month of a soldier leaving active duty.

c) VA should have full access to military medical databases to better prepare for service-related illnesses, and for designing and implementing the transferable electronic medical record.

Improve accessibility of military medical care for Guard and Reserve members (also see Command Level #2)

Background: No staffed clinic currently exists at the Maine military bases. Ill soldiers are taken to Togus for care. This limits continuity of care, and

Intervention:

A medical clinic should be staffed with a licensed medical provider during Guard drill weekends, to attend to medical problems that servicemembers feel may have arisen as a result of their prior service or their drill duties.

Make all anthrax vaccine safety data, properly anonymized, available for public scrutiny

Background:

The safety of anthrax vaccinations has been controversial since the 1991 Gulf War. Thirteen Congressional hearings have heard testimony on the vaccine; numerous GAO reports and Institute of Medicine reports on the vaccine have been written. Other expert groups have also issued recommendations on the vaccine.[3] All these groups have agreed that the long-term safety of the vaccine is questionable, as no reliable data have been presented to resolve the controversy. Furthermore, a 2007 GAO report,[4] citing officials at the CDC and the military Vaccine Healthcare Centers, stated:

> *Officials from the VHC Network and CDC estimate that between 1 and 2 percent of immunized individuals may experience severe adverse events, which could result in disability or death. Some of these events may occur coincidentally following immunization, while others may truly be caused by immunization.*

DoD's Assistant Secretary of Defense for Health Affairs, Dr. S. Ward Casscells, concurred with the report's findings and results.

Congress required the Defense Department to develop a force-wide electronic database of soldiers' health, including vaccinations. The name of this database is the Defense Medical Surveillance System (DMSS). The Institute of Medicine's 2003 report[5] on the CDC's anthrax vaccine research program stated:

> *Finding: DMSS is a uniquely valuable resource for testing hypotheses regarding medically significant health effects of exposure*

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[3] http://merylnass.googlepages.com/Selectedfindings.doc

[4] GAO-07-787R. Military Health: DOD's Vaccine Healthcare Centers Network. June 29, 2007. http://www.gao.gov/new.items/d07787r.pdf

[5] Institute of Medicine committee to review the CDC anthrax vaccine safety and efficacy research program. An assessment of the CDC anthrax vaccine safety and efficacy research program. National Academies Press. Washington, D.C. 2003. Pages 76-77.

to AVA or other vaccines, especially those that might arise several months after vaccination but within the period of active duty.

Recommendation: Analysis of DMSS data should be the primary approach for investigation of possible AVA[6]-related health effects of medical significance that occur within the typical period of active duty following vaccination.

However, despite expectations of the Institute of Medicine committee that quarterly reports on health status related to anthrax vaccine would be issued, no reports from DMSS have been issued, apart from the report requested by the Institute of Medicine in 2001.[7]

The CDC and the military Vaccine Healthcare Centers also have large datasets on anthrax vaccine safety. However, a CDC study[8] of anthrax vaccine safety published on October 1, 2008 inexplicably failed to provide information on 95% of 229 serious adverse events that occurred during its trial of anthrax vaccine safety in 1563 subjects.

VA's Research Advisory Committee on Gulf War Veterans' Illnesses asked in its 2004 report[9] for VA to study anthrax vaccine in veterans to see whether vaccine use is related to development of Gulf War Illnesses.

However, none of these databases have been used to resolve the question of anthrax vaccine safety, despite repeated recommendations to do so. Yet the existing data has been acquired at taxpayer expense, and 2 million servicemembers have received mandatory anthrax inoculations since the Gulf War.

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[6] The licensed anthrax vaccine was named AVA (anthrax vaccine adsorbed) until 2002; it is now named Biothrax.

[7] Bob Evans. Despite promises that hospitalizations after anthrax vaccinations would be reported, the Pentagon withheld data on more than 20,000 cases. Daily Press; Hampton Roads, Virginia. December 4, 2005. (First of four parts).

[8] Nina Marano, DVM; Brian D. Plikaytis, MSc; Stacey W. Martin, MSc et al. Effects of a Reduced Dose Schedule and Intramuscular Administration of Anthrax Vaccine Adsorbed on Immunogenicity and Safety at 7 Months. JAMA. 2008;300(13):1532-1543.

[9] Research Advisory Committee on Gulf War Veterans' Illnesses. Scientific Progress in Understanding Gulf War Veterans' Illnesses: Report and Recommendations. September 2004.

Intervention:

Congress should enact legislation requiring that federal agencies (DoD, CDC, FDA, NIH, VA) make their anonymized, safety-related data on anthrax vaccine fully available for study by independent scientific investigators, in a timely manner.

Repeal the Public Readiness and Emergency Preparedness Act of 2005 (Division C of PL 109-148)

Background:

Following the anthrax letters scare and concerns about pandemic influenza, the controversial Public Readiness and Emergency Preparedness Act (PREPA) was attached to a defense authorization bill in December 2005, passed, and enacted into law. The bill provides an almost complete liability shield for those involved in manufacturing or administering "covered countermeasures" for pandemics, and further shields "government program planners" from liability.

The bill's immunity shield goes into effect after the Secretary of DHHS issues a directive declaring a particular disease emergency. However, the bill does not require that an emergency exist, nor that there be any evidence of increased risk of the disease.

On October 1, 2008 Secretary of DHHS Mike Leavitt issued a directive establishing an anthrax emergency under PREPA, providing immunity from liability for many anthrax countermeasures. The designated emergency period extends through 2015. A memo from DHS Secretary Chertoff to DHHS Secretary Leavitt dated September 23, 2008 specified that there was no current anthrax emergency or heightened risk of one.

On October 10, 2008 Secretary Leavitt issued additional emergency directives for smallpox, botulinum toxin and radiation sickness.

On October 1, DHHS purchased approximately $400 million dollars worth of anthrax vaccine to add to its stockpile. On October 23, CDC's Advisory

Committee on Immunization Practices reversed a 2002 recommendation and approved the use of anthrax vaccine in civilian first responders.

It is clear to the Commission that the PREPA bill is being used to invoke non-existent emergencies to provide immunity from liability to manufacturers of "covered countermeasures" and to government officials who sanction their use.

Furthermore, since products must be in a late stage of development to be designated for human use as a "covered countermeasure," it is uncertain whether PREPA will aid in promoting development of new countermeasures, the purpose for which it was passed.

The Commission has heard multiple testimonies regarding severe adverse reactions to anthrax and smallpox vaccines in servicemembers. We find that removing liability protection, while at the same time expanding use of such products, is a dangerous mistake. We suspect that invoking emergencies where none exist is a cynical method of tort reform, rather than an exercise in public health.

Intervention:

Congress should rescind PREPA and revoke the directives and liability protections currently in place.

Improve the medical disability process for servicemembers

Background:

The Commission has heard testimony on the complex and prolonged process of leaving active duty due to medical disability, and the difficulties faced during the disability process. This often involves separate disability evaluations while on active duty and later as a veteran. The system is complex and most veterans find it arduous. The decision-making process lacks uniformity.

One veteran explained that after becoming ill it took him 4 years of processing within the military and another four years in the VA system before he was finally given a 100% disability for multiple sclerosis. Some

reservists report being placed on "medical hold" after becoming ill while activated, and have been prohibited from returning to civilian life for periods up to three years, while receiving only limited medical treatment.

In late October 2008, reports surfaced of many VA regional offices that improperly shredded veterans' benefit claims and other important documents.[10] Our Commission is concerned about errors of this kind, which may be widespread in the VA system.

In July 2007 a Presidential Commission issued its report on improving the care of wounded warriors.[11] We are impressed with the wisdom of its recommendations, and wish to go on record as strongly supporting them. The report is titled: Serve, Support, Simplify: President's Commission on Care for America's Returning Wounded Warriors Issues Six Groundbreaking Patient and Family Centered Recommendations.

Their recommendations that are especially germane to the work of our Commission include the following:

a) Assistance and support should be provided to injured servicemembers to navigate complex medical and disability systems

b) DoD should maintain its authority to determine fitness to serve in the armed forces after injury or illness. Once soldiers are found not fit for duty, DoD should provide a standard lump sum payment based on time served and discharge them in a timely manner. (DoD should have no need to diagnose complex illnesses or treat such soldiers for long periods, and should have no reason to assign them to "medical hold.")

c) There should be a single, simplified disability process, administered by VA, which will establish the disability rating, compensation and benefits.

d) Rapidly transfer patient information between DoD and VA

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[10] http://www.usnews.com/articles/news/national/2008/10/31/military-veterans-benefit-claims-records-wrongly-headed-for-va-shredders.html

[11] Co-chairman of the Commission, Senator Bob Dole, describes the 6 recommendations of the Commission at http://www.bobdole.org/issues/article.php?id=76

A pilot program utilizing a single VA disability assessment for active servicemembers was begun in early 2007.[12] It achieved a significant reduction in the time needed to get injured soldiers disability and appears very successful.

Interventions:

Congress should enact legislation, as needed, to implement above recommendations a) through d). Veterans Affairs Congressional Committees should investigate improper shredding of records and widespread loss of medical and administrative records.

Resolve the issue of undiagnosed illnesses in a timely manner

Background:

Veterans of the Vietnam and 1991 Gulf Wars often waited many years before the multiple symptoms they experienced were found to be service-connected. This was a result, in part, of limited medical knowledge of their complex illnesses, and limited knowledge about the effects of the toxic exposures experienced by the veterans. Choices of research areas to clarify their illnesses have been controversial, with most initial funding for Gulf War illness research going to stress and psychological causes. Even now, 17 years after the Gulf War ended, most medical providers, even in VA hospitals, are unfamiliar with how to diagnose and treat Gulf War illnesses. Current VA guidelines for Gulf War illnesses emphasize psychological treatments for the disorder, although VA's Research Advisory Committee on Gulf War Veterans ' Illnesses called for updated, more scientific guidelines.[13]

In 2007, Dr. Michael Kilpatrick, deputy director of Force Health Protection and Readiness at the Department of Defense. stated that 15-20% of current deployed troops to OIF and OEF are returning with ill-defined medical symptoms. Thus a new generation of veterans may be facing the same problem of undiagnosed illnesses and the consequent delay in establishing service-connection.

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http://www.navytimes.com/news/2008/11/military_disability_test_expansion_110608w

13 http://www1.va.gov/rac-gwvi/docs/Letter_Recommendations_Feb012007.pdf

Interventions:

a) To require the Secretary of VA to make strong efforts, through research and medical record reviews, to identify commonly experienced clusters of symptoms early in servicemembers returning from war, including our current wars.

b) To require the Secretary of VA to designate any medically significant cluster of symptoms returning service members are experiencing as compensable; significant undiagnosed illnesses should not be excluded from treatment and compensation decisions

c) To require the Secretary of VA to update VA's treatment guidelines and medical provider training in line with the most recent scientific discoveries, as recommended by VA's Research Advisory Committee on Gulf War Veterans' Illnesses.

State Command Level:

Medical Record Documentation Receipts

Background:

Soldiers and veterans have expressed concerns about missing data in their military medical records,[14] and the loss or absence of civilian medical records that they have supplied to the Guard. National Guard medical providers have expressed concerns about soldiers not sharing important information on their health status (from civilian medical facilities) with the Guard.

Intervention:

Both problems could be partially alleviated were the National Guard Bureau to institute a policy requiring that a "documentation receipt" be

[14] The issue of missing records was validated as a major problem by the President's Commission on Care for America's Returning Wounded Warriors in its 2007 report.

placed in the medical record and a copy given to the service member when he/she submits new health information to military medical staff.

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